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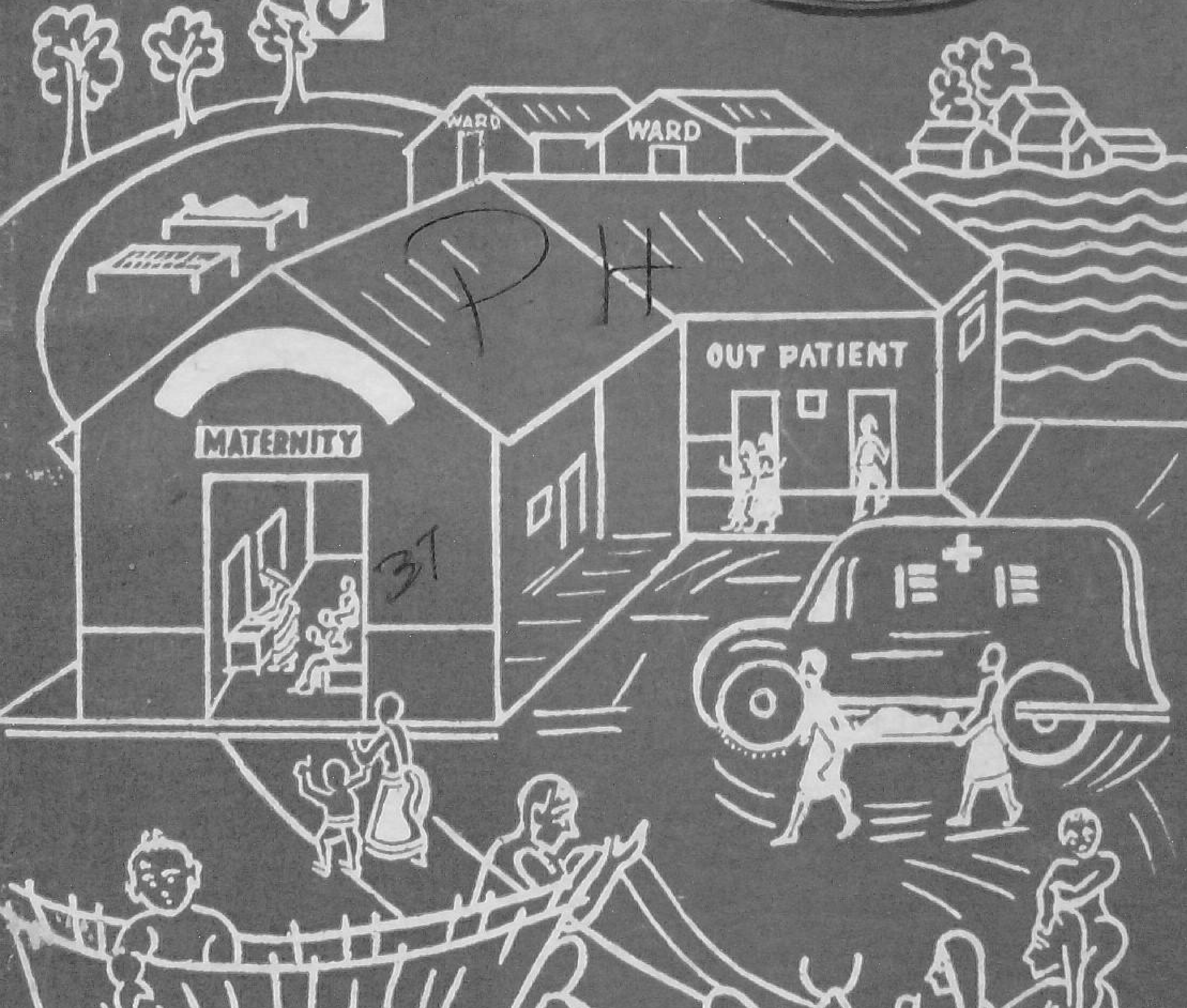
Primary Health Centre



OFFICE OF THE PRINCIPAL
19 JUL 1961
PATTUKKOTTAI
EXTENSION TRAINING CENTRE

MINISTRY OF COMMUNITY DEVELOPMENT & COOPERATION
(DEPARTMENT OF COMMUNITY DEVELOPMENT)
GOVERNMENT OF INDIA

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A Primary Health Centre

PREFACE

It is more than two years since the brochure was last published. During this period I have had the opportunity to visit different States and have gained considerable field experience. Participation in national and international conferences on the subject of Rural Health has also widened my scope of knowledge. Further some administrative changes have taken place in connection with the allocation of Blocks necessitating a review of the staff and training programmes. Assistance from UNICEF and WHO has also been procured. Administrative procedures have to be reviewed in the light of democratic decentralization. With the increasing emphasis on preventive health care, the orientation of medical and health personnel at all levels has become a necessity and calls for early establishment of Orientation Training Centres in each State. The present effort is to embody all these factors in this new edition, so that the Administrative Medical Officers may be able to make use of these. I am grateful to all the Development Commissioners, Administrative Medical Officers and Directors of Public Health for the field experience which I have gained in their States. I would like to emphasise again that I have attempted to record the latest thinking on the subject for development of effective health services for rural areas. The Administrative Medical Officers and Directors of Public Health may modify these suggestions to suit their special requirements. The objective of this brochure is the same as before.

Krishi Bhavan,
NEW DELHI
15th August, 1960

BARKAT NARAIN
Adviser (Health)
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and Cooperation

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INTRODUCTION

Community Development has been defined as "a process designed to create conditions of economic and social progress for the whole community with its active participation and the fullest possible reliance upon the community's initiative". This process implies the integration of all activities, including health, leading to the all-round welfare of human beings. As such, it is a multi-purpose programme involving all aspects of development essential for improving the socio-economic conditions of the people with emphasis on agriculture.

Health is an integral part of Community Development, because standards of health are closely linked with economic and social structure of the community. This point was well illustrated by the Union Minister for Health in his inaugural address on the occasion of the Regional Rural Health Conference sponsored by the Regional Office for South East Asia, World Health Organisation in December, 1957. He said:—

> "Rural health programmes which are not supported or accompanied by programme of rural reconstruction embracing the basic requirements of agriculture, education and economic and social betterment, have little chance of producing the results which may be expected of them."

Health care in the Community Development areas is of an integrated pattern combining preventive and curative services with emphasis on the preventive aspect. This concept is in keeping with the recommendations of the Health and Survey Committee (Bhore Committee) and also with the recommendations of the COPP Committee set up by the Planning Commission. The World Health Organisation has also endorsed the view that there should be integrated health care through the Primary Health Centre in the rural areas.

To achieve the above objective, it was decided to establish a Primary Health Centre and three sub-centres in each Community Development Block to render comprehensive health care to the people living in the area. For administrative convenience, the country has been divided into 5,000 Blocks; each Block consists of approximately 66,000 population and about 100 villages. At present, there are 2,907 Blocks in operation covering a population of 1,923.00 lakhs and approximately 3,79,646 villages. The entire country will be covered by Blocks by the end of March, 1963. Each Block will have a Primary Health Centre and three sub-centres from where the health services will radiate into the homes of the villagers. It must be made clear that the establishment of these services is in addition to the existing health services in the areas; intention being to intensify rural health services. The importance and urgency of this service has been emphasised by our Prime Minister—

> "While our cities and towns require to be looked after much better than they are at present, it is really the village that has been terribly neglected and cries loudly for succour. Public health must, therefore, go to the village, and the village should not be compelled to come to the town in search of it". (Pandit Nehru).

2. Planning

With effect from 1st April, 1958, the distinction between the National Extension Service and Community Development Blocks has been abolished. The allocation of the Blocks is now made during the Stage I period, which lasts for five years and later they become Stage II Blocks (formerly known as "post-intensive" Blocks). All the States have been demarcated into Blocks. Allocation is made by the Ministry of Community Development and Cooperation on 1st April and 2nd October each year. All Stage I Blocks have a "pre-extension period" of one year, *i.e.* intimation is given to the State Governments about the allocation of the number of Blocks a year in advance. The State Governments decide what areas are to be brought under Stage I. The intention of "pre-extension period" is to give sufficient time to the State Governments to survey and plan the whole integrated programme, which includes location of Block headquarters, preparation of building plans, recruitment of staff and training, etc. This period is of great value for the planning of health services because it gives the Administrative Medical Officers sufficient time to organise a quick survey of existing health activities, health needs and health problems of the area, if this data is not already available. This also gives him time to review the staff requirements and the training programmes. While considering the question of staff requirements, it is necessary to provide for leave, sickness and training reserve. High priority should be given to the selection of sites for the Primary Health Centre and sub-centres, so that steps can be taken for the preparation of building plans, acquisition of land, if necessary, and financial sanctions, etc. He can issue instructions for the preparation of indents for medical and surgical equipment, drugs, furniture, etc. All this "pre-planning" can be initiated through the District Health Organisation. The object of this is that when a Block comes into Stage I, there will be no time lag in the establishment of health services.

(i) Responsibility for developing Health Services

It must be emphasised that it is the responsibility of the Administrative Medical Officer of the State concerned to take the initiative in developing the health services. Immediately on receipt of information from the Development Commissioner about the location of pre-extension Blocks, he should contact his representative at the district level and take appropriate action regarding health surveys, planning, etc.

(ii) Appointment of Senior Health Officer for the Administration of Primary Health Centres

The programme for establishment of Primary Health Centres is expanding very rapidly and by 1963, the whole country will be covered by this programme. The establishment of the Primary Health Centres involves a great deal of time for finalizing administrative procedures with regard to site, construction of buildings, provision of staff, training and inservice training, etc. Therefore, it is considered essential that a whole time senior Health Officer be appointed in each State in the Office of the Director of Medical Services/Public Health. In this connection, the Union Ministry of Health have already issued instructions to all the State Governments.

3. Primary Health Centre

(i) Location

The Primary Health Centre should be located at a convenient place preferably, but not necessarily, at the headquarters of the Block and should be the focus from where the health activities radiate into the area covered by the Development Block. The location of the site is decided by the Block Development Committee (Block Samitis where Panchayati Raj has been established) in consultation with the District Medical and Health Officers who are members of the Committee. In selecting the site, the following points are to be borne in mind:

(1) Health needs of the area as indicated by a survey;

(2) Forthcoming participation of the people in the form of donation of land and contribution towards capital expenditure;

(3) Easy accessibility and facilities for communications including post and telegraph and roads;

(4) Accessibility to Referral Hospitals with adequate equipment and specialist services.

(ii) Building

The building housing the Primary Health Centre should be simple in design and adapted to local environments. There should be sufficient accommodation for a consultation room, diagnostic facilities, dispensary, minor operations, maternal and child health and family planning services and a waiting room. There should be at least six indoor beds for emergency. The Primary Health Centre building should be provided with potable water supply and rural sanitation, hand flush latrines and urinals. A garage must be constructed for a vehicle. A draft plan prepared by the Chief Architect of the Directorate General of Health Services is enclosed for reference (Appendix "C"). The Administrative Medical Officers may like to adopt this plan with modifications, if any, to suit local requirements.

In most of the Primary Health Centres, there is plenty of space available which may be utilized for setting up a demonstration showing a few important types of rural sanitary latrines and urinals, so that the villagers coming to the centres can be shown these facilities. It is also suggested that wherever land is available, a model vegetable garden should be developed. These demonstrations can be useful for teaching better sanitary and dietary practices. Similar demonstrations may also be developed adjacent to the sub-centres wherever land is available.

(iii) Staff Quarters

Residential accommodation for the staff is absolutely essential and a pre-requisite to attract doctors and other health workers to the rural areas. Presence of the staff adjacent to the Primary Health Centre and sub-centres is also necessary for prompt service.

4. Basic Services

The services which radiate from the Primary Health Centre and the sub-centres are :

(1) Medical relief.

(2) Maternal and child health care including family planning and training of Dais.

(3) School health.

(4) Health education.

(5) Environmental sanitation—with high priority for safe drinking water.

(6) Control of communicable diseases with priority for malaria and small-pox.

(7) Collection of vital statistics.

5. Staff

To render the basic services, the staff should, at least, consist of the following personnel in addition to the existing medical and health staff in the Block area:—

Medical Officer	1
Compounder	1
Public Health Nurse/Lady Health Visitor	1
Auxiliary Nurse Mid-wives/Mid-wives	4
Sanitary/Health Inspector	1
Class IV Staff	2

The State Governments have agreed to provide a driver and maintenance charges for the vehicle.

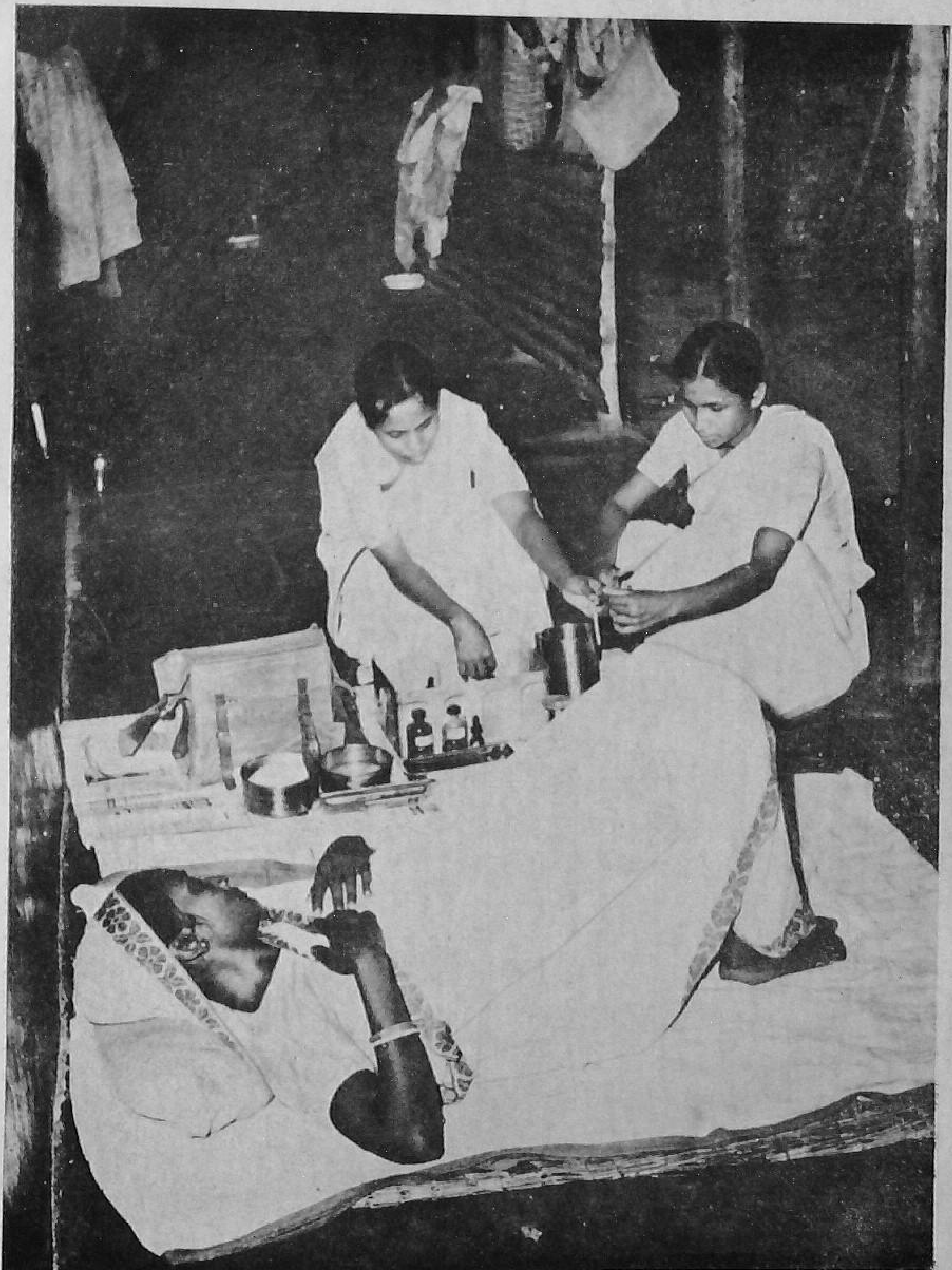
The above staff pattern was suggested because of the paucity of trained personnel and financial resources. It has been made clear to the State Governments that they should employ additional staff if personnel and funds are available. As a matter of fact, some States have already done so. It is realised that the staff mentioned above may be inadequate for 66,000 population; but when more funds and personnel are available in the Fourth or the Fifth Plan, there will be three such units in each Block, so that one Primary Health Centre and three sub-centres will serve a population of about 25,000 only.

There has been some difficulty in recruiting the staff for the Primary Health Centres. The following suggestions are made to attract suitable health workers to rural areas :—

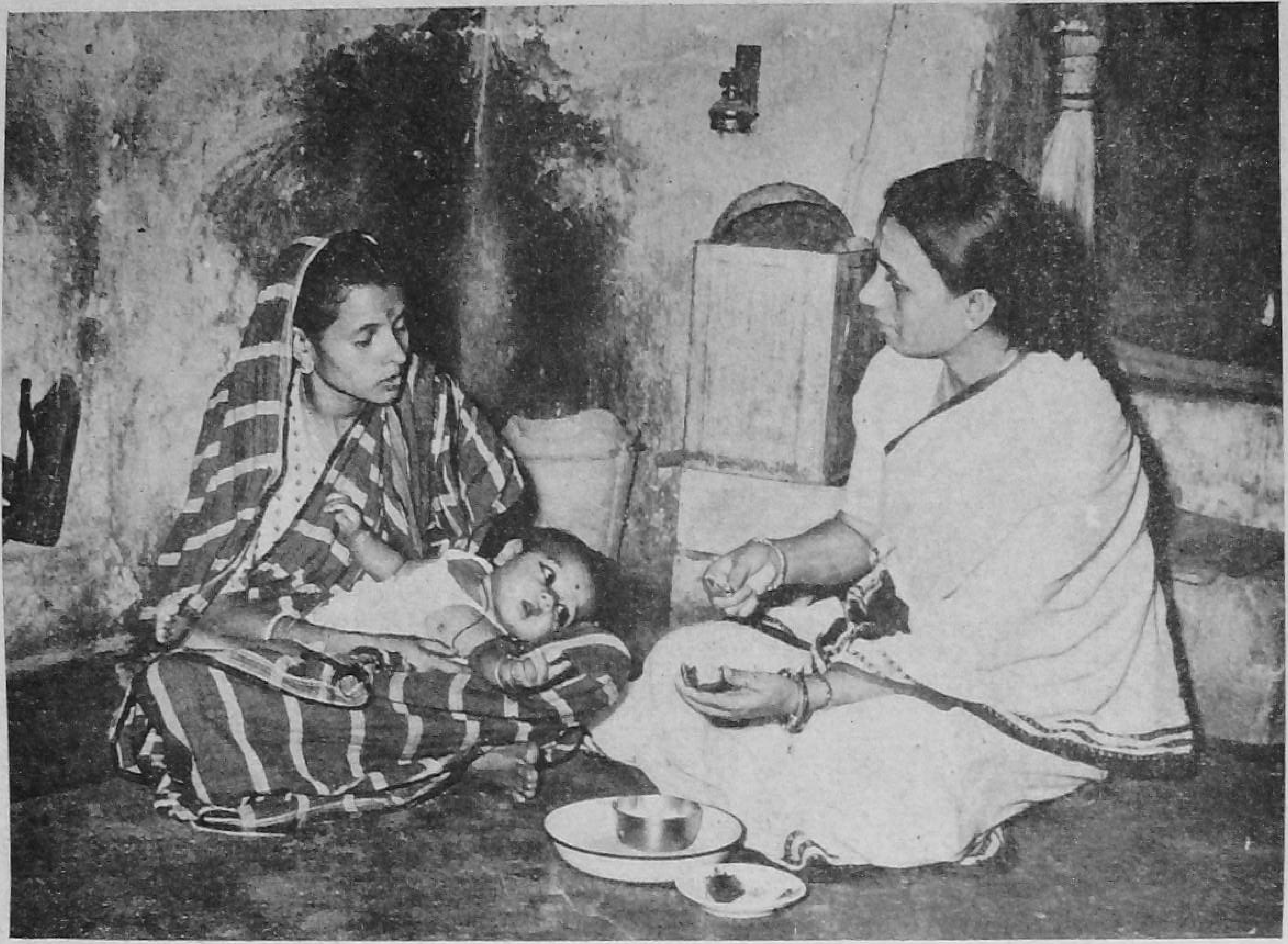
(1) Security of tenure—this can be assured by recruitment to the regular cadre of the Health Department of the State.

(2) Residential accommodation—this is most important.

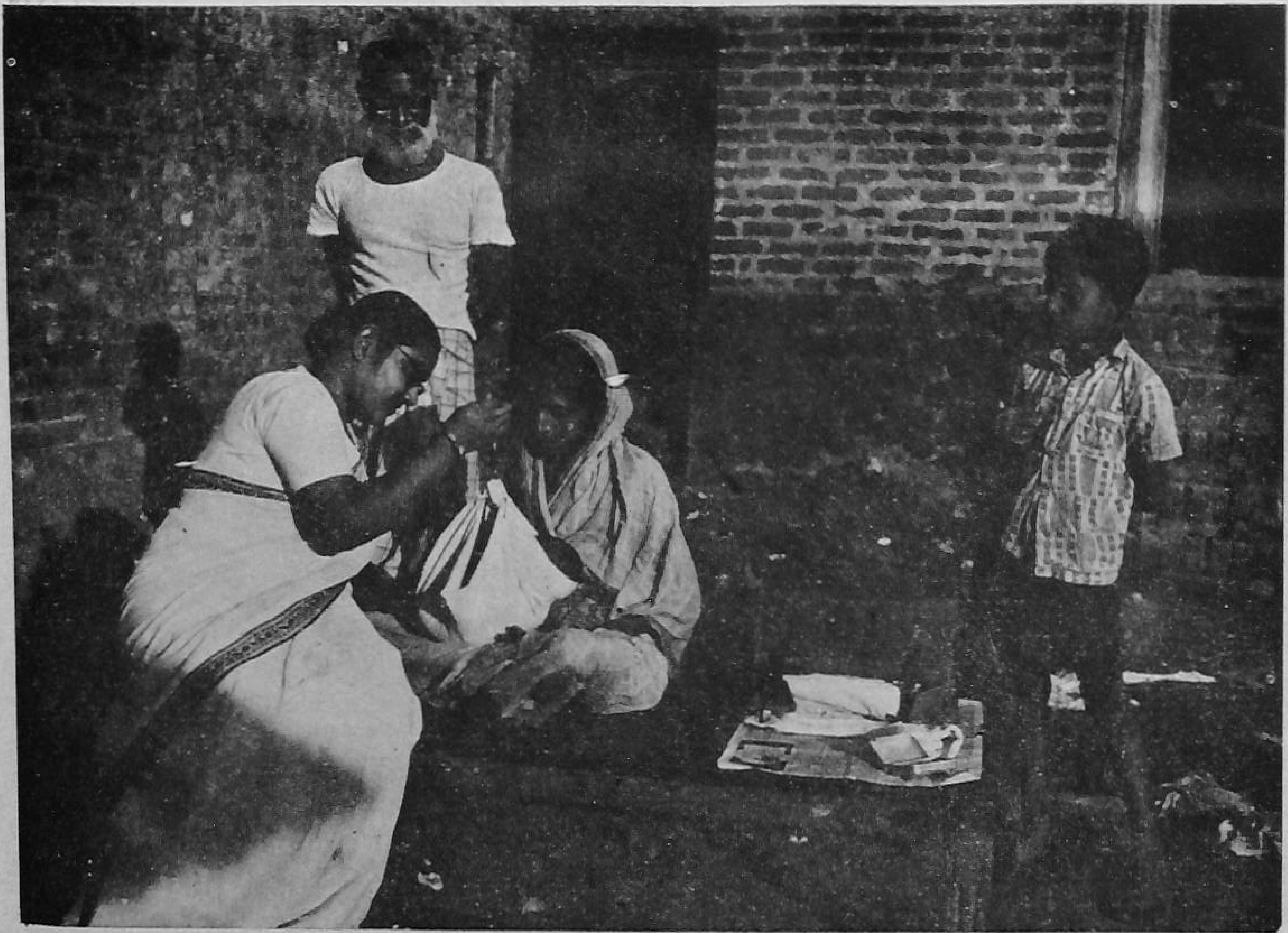
(3) Adequate rural health and non-practice allowance—this is essential because the Medical Officer in charge of the Primary Health Centre has to carry out a lot of rural health work and if he has to do this effectively, he has no time for private practice.



Domiciliary Midwifery



Home visits—infant care



Home visits—weighing a new born baby

Infant clinic—baby is being weighed

Home visits by Public Health Nurse in a Tribal Block

Domiciliary medical care—teaching father

Domiciliary visits—infant care

Female Section (Primary Health Centre)

(i) Duties of the Staff

These have been indicated in Appendix "A". The Administrative Medical Officers will, no doubt, amend these, if necessary, to suit local conditions.

6. Suggestions for Execution of Basic Services

With regard to the basic services, a few points are highlighted below. The Administrative Medical Officers of the States will naturally prepare an operational guide, if one has not already been prepared for the detailed execution of the health programme in the Community Development Blocks.

(i) Medical Care

Provision of medical care is a basic function, and as such, the Medical Officer in charge of the Primary Health Centre apart from giving medical care at the Primary Health Centres has to visit the sub-centres and other villages to give out-patient treatment to the sick. For these visits, he should have a fixed programme which should be intimated to the Gram Sevaks so that they can inform the villagers who may wish to consult the doctor. Treatment should be combined with health education so that the treatment would not be an end in itself but an introduction to prevention. During these visits, the Medical Officer has to supervise the work of the Lady Health Visitor/ Public Health Nurse and the Sanitary/Health Inspector. Once a month the Medical Officer, Public Health Nurse/Lady Health Visitor and Sanitary Inspector/Health Inspector should jointly visit each sub-centre to discuss health problems pertaining to the area served by the sub-centre. In addition, the Medical Officer will inspect the midwifery kit maintained by the Auxiliary Nurse Midwife/Midwife and make sure that necessary stocks of dressings and drugs are available at the sub-centre. They should also contact, whenever possible, the village leaders and school teachers.

(ii) Rural Medicine Chests

As some of the villages may be out of the way or inaccessible for lack of adequate roads or due to weather conditions, it is suggested that a rural medicine chest be provided at the rate of at least one per Gram Sevak's circle. This medicine chest may be kept with the school teacher or the Sarpanch if a Panchayat exists. Some of the States are already maintaining these medicine chests. As to the contents and the person to be in charge of the medicine chest, the matter is left entirely to the discretion of the Administrative Medical Officers; the most important point is that he should give clear instructions about "refilling" of these medicine chests.

(iii) Maternal and Child Health

Out of the four Auxiliary Nurse Midwives, one is located at the headquarters of the Primary Health Centre and one each at the sub-centres. The Public Health Nurse or the Lady Health Visitor, who is stationed at the headquarters of the Centre will visit each sub-centre once a week on a fixed day. At the sub-centre, she will conduct ante-natal, post-natal and well-baby clinics. She will supervise

the work of the Auxiliary Nurse Midwives and examine the register of births and deaths and home visits maintained by them. She will arrange for immunisation of infants and toddlers under the care of the Centre. During these visits, she will contact the members of the *Mahila Samitis* (women's clubs) and discuss with them ways and means of improving the health of the women and children and improvement of the homes.

Maternal and child health services are an integral part of the total health programme and have to be combined with advice on nutrition, control of communicable diseases and improvement of environmental sanitation. In other words, both at the main centre and the sub-centres health education must be combined with ante-natal, natal and post-natal services.

The care of the infants and well-babies should receive special attention.

(*iv*) *Training of Dais*

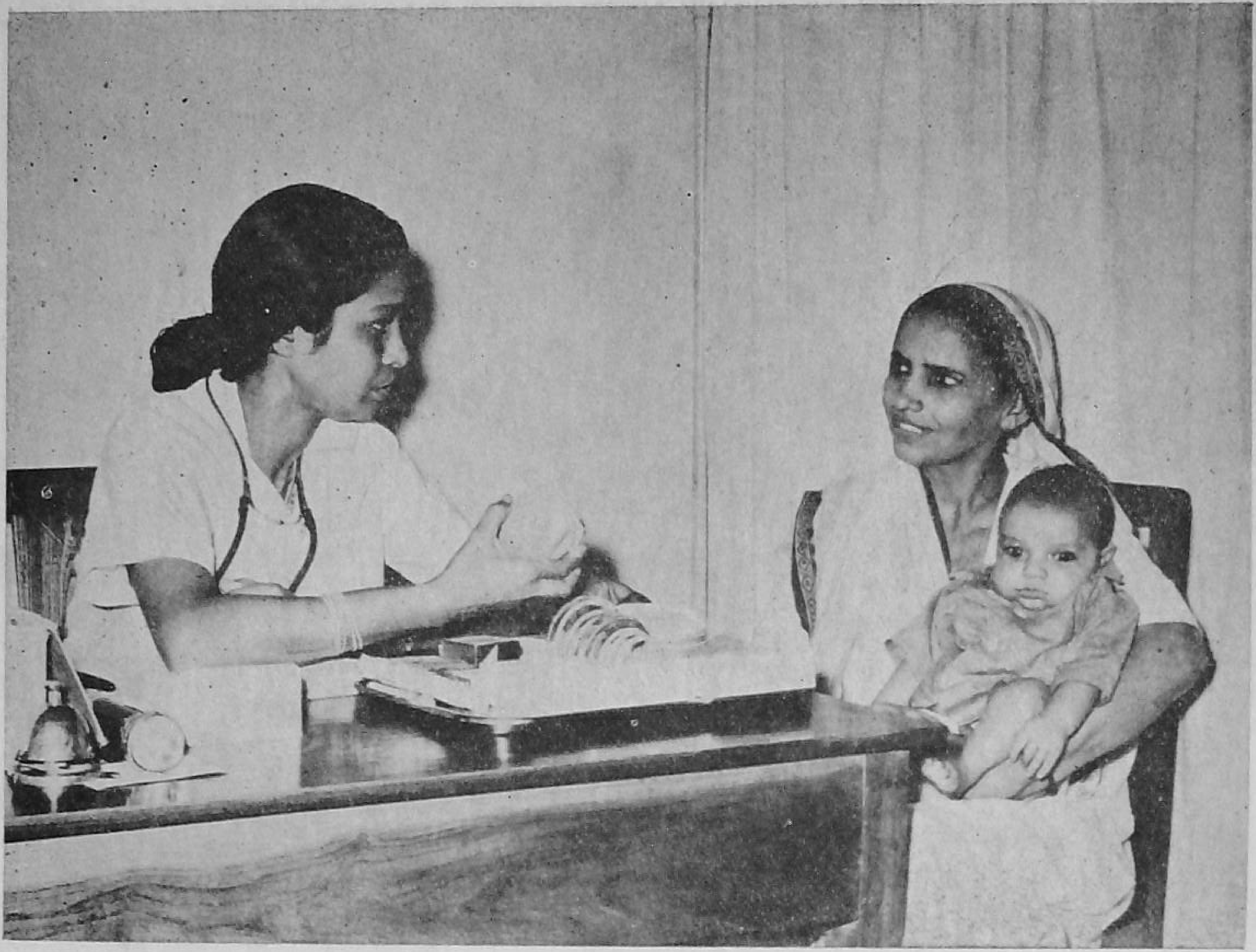
Untrained women (barber women, chamain, etc.) continue to perform domiciliary midwifery in a most unhygienic manner in all except one or two States. This is the main factor responsible for maternal and infant deaths. On account of certain social pattern majority of expectant mothers come for ante-natal care, but still utilize the services of these untrained women to massage and wash the clothes and help in the disposal of soiled clothing, etc. It will be a long time before we are able to provide a trained midwife or Auxiliary Nurse Midwife for every village and can change the existing social pattern; therefore, the value of these untrained women will continue. As such, it is necessary to take immediate steps to give a simple elementary training to these women so that they may perform their duties in a clean and hygienic manner. The Union Ministry of Health has sponsored a scheme for training of these women and has offered 100 per cent grant for their training. Recently the United Nations Evaluation Team for Community Development Programme has also stressed the necessity of training such women for reasons mentioned above. A few States have already initiated this training. It is suggested that in those States where domiciliary midwifery is performed by untrained women this training should be started at an early date.

(*v*) *Family Planning*

Family Planning has been incorporated as an integral part of the total health programme because it is of vital importance for improving the health and socio-economic conditions of the family and the community. Our Prime Minister (Pandit Nehru) has so well expressed the reasons for family planning. He has stated that one of the principal objectives is "to lessen the rate of growth of population increase......but there are other aspects also, to give a fuller life to the family and more particularly to the mother and the children". He has further observed that "any marked success in this movement will depend on two factors—(*i*) a wide approach to our rural population; and (*ii*) simple and cheap methods".

In view of the increasing demand by married men and women for sterilization, it is considered necessary that the Administrative Medical Officers may provide adequate facilities for sterilization at the district and the sub-divisional hospitals. Some of the States

Health Education in Family Planning



Family Planning—advice on methodology

have already provided such facilities and in addition, a few States have organised a mobile team of specialists for sterilization operation. These mobile teams visit sub-divisional hospitals and Primary Health Centres where these operations are carried out by specialists. The visits of the team are, naturally, regulated by the requirements of the area as intimated by the Medical Officers in charge of the sub-divisional hospitals and Primary Health Centres.

It may also be mentioned that the Family Planning Board have agreed to pay a sum of Rs. 1,500 annually to every Primary Health Centre, dispensary and sub-divisional hospital for purchase of contraceptive material and appliances.

The Union Ministry of Health have also made arrangements for training of doctors and other health workers in this programme.

Planning the family is a very personal matter and, therefore, it is necessary to approach individuals in addition to "family planning education" for the community and the masses. The utility of the non-technical field workers employed in the Community Development Block cannot be over-emphasised for educating the people to seek their acceptance for family planning and also for providing necessary information about the location of clinics and centres where such advice and material are available.

The officer in charge of Family Planning and Health Education in the States should visit the training centres for the Community Development workers and give talks to the trainees. The subject of Family Planning has already been included in the syllabus of all the training centres. These workers, if adequately trained, can help in changing the existing attitudes of the people in relation to parenthood and procreation and make them understand the relation of population to the economic growth. In a number of Blocks projectors have been provided to the Social Education Organisers. District Health Officers should provide films on family planning education and other relevant material pertaining to this programme to the Social Education Organisers and Mukhya Sevikas, so that these can be shown to the people.

The role of the voluntary organisations in this programme is very important and, therefore, every effort must be made to coordinate our activities with those of the voluntary organisations.

(*vi*) *School Health*

This programme concerns child's growth and development—physical, emotional, intellectual and social. A complete health examination must be carried out of every child at the time of admission, and repeated after five years and before leaving the school. Arrangements should be made for the correction of defects, if any are detected after medical examination. School children are comparatively more susceptible to infectious diseases than adults and, therefore, it is necessary that the District Health Officer should arrange for immunisation of school children particularly against small-pox and cholera. School is an ideal place for inculcation of health habits and correct attitudes towards health. For this purpose, adequate provision must be made for safe drinking water supply, latrines and urinals. In fact, provision of these facilities should be made a condition for sanctioning grant-in-aid to a school.

School Feeding

Nutrition of the children should receive special emphasis and arrangements should be made for school feeding programme. School feeding should not be developed as an isolated service for school children. It should be integrated with the school curriculum as a whole and should form an important part of the school health programme. Utmost importance should be laid on associating school feeding programme with education in nutrition and other measures to improve diets. Such a programme must extend beyond the school, since improvement in diet requires a co-operative effort on the part of the school, the home and the community. The feeding programme should be designed to supplement the important nutrients deficient in the home diet so that the food the child receives at school and at home will provide him with a nutritionally satisfactory diet.

School children should be encouraged to cultivate kitchen gardens and orchards wherever possible.

This programme should be made the responsibility of the Panchayats wherever they exist and should be executed through the help of the *Mahila Samitis.* The teacher and his or her staff must help in the distribution of the meal. No school health programme can be successful without the active cooperation of the school teacher. He is in close and continuous touch with the students in their daily routine. It would be useful if teacher-parent associations are established wherever it is possible.

(*vii*) *Health Education*

"Health Education like general education is concerned with change in knowledge, feelings and behaviour of people".

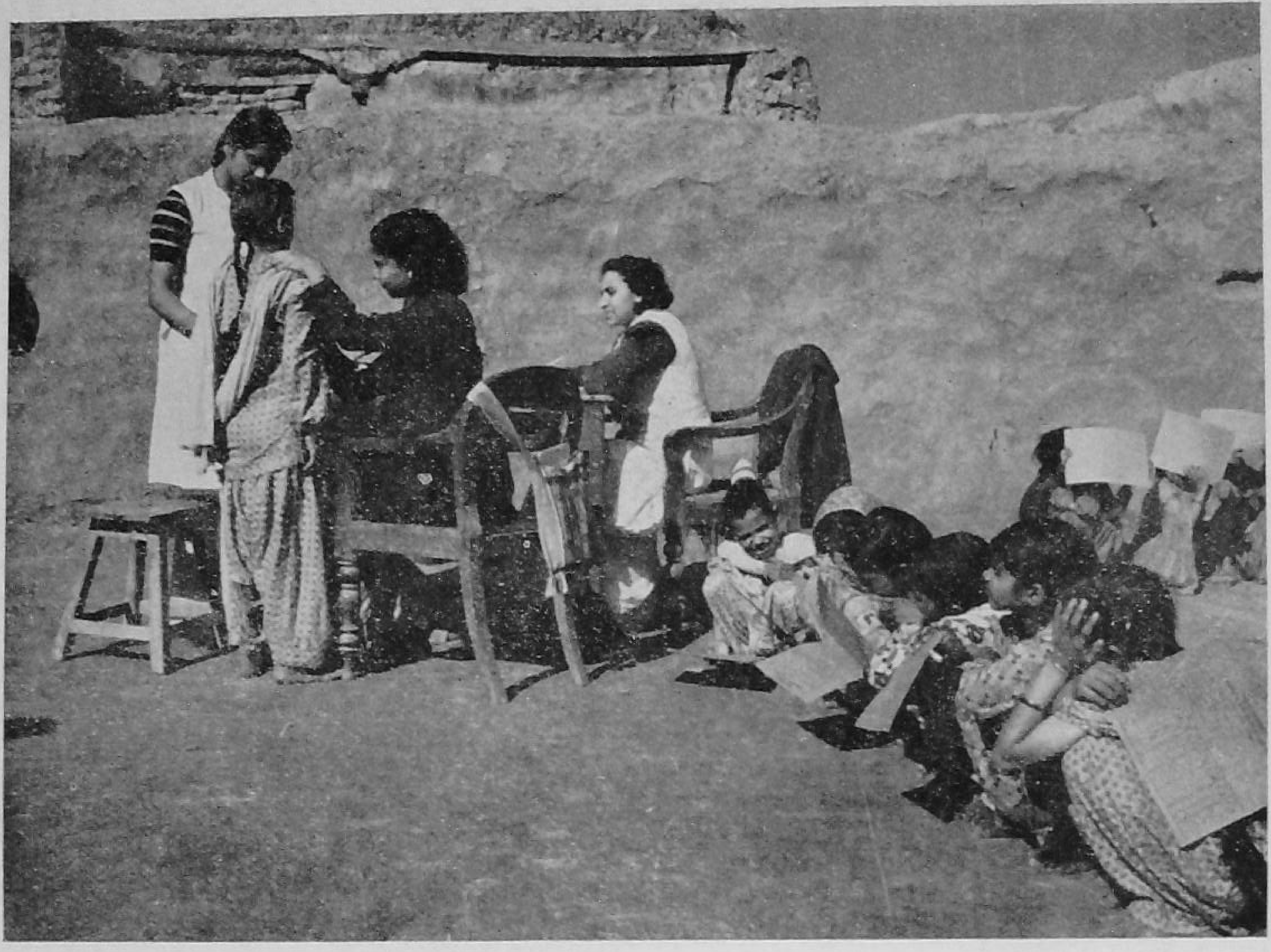
Health Education must form an essential part of the health programme. All the medical and health personnel employed in the Community Development areas must take an active part in the dissemination of this knowledge so essential for man's well-being. In this effort, there must be full co-ordination between the health and education authorities particularly at the District and the Block level and such education must begin with the child and go right up to the adult. Full advantage must be taken of the field personnel in the Community Development areas and audio-visual aids supplied to the Social Education Organisers in the Blocks.

The new ideas and concepts which health education introduces can produce good result only if they can be integrated with the existing values of the people concerned. For the worker in the field of health education, as in any other programme for human development, the importance of good human relations cannot be over-emphasised. The field worker must remember the value of first impressions when he makes contact with the people. The methodology of approach should be such that it makes the worker acceptable, it should be friendly and human and he should be ready to work with the people; the worker has to be exceedingly patient and should be able to talk to the people in a 'language' they understand.

(*viii*) *Environmental Sanitation*

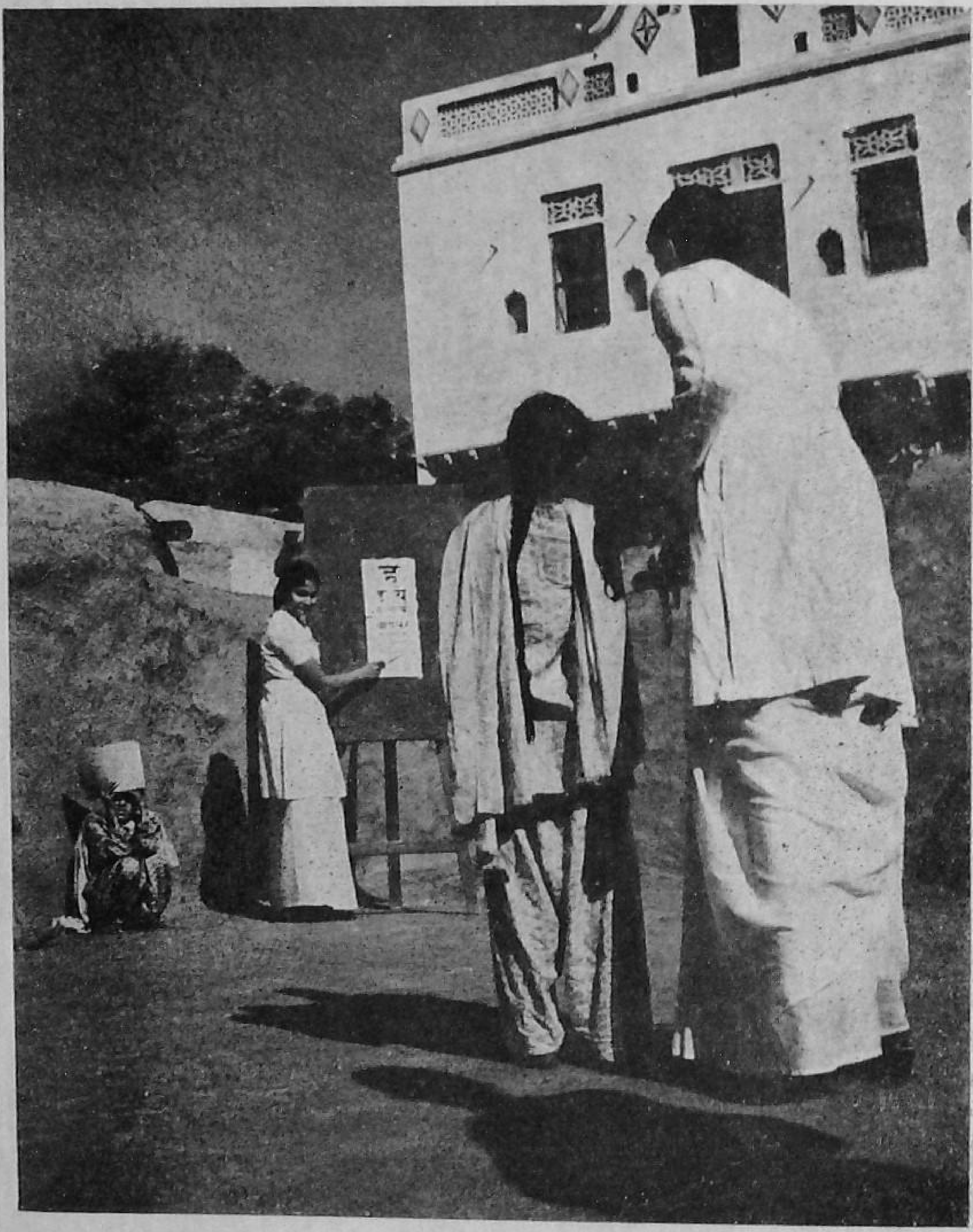
For the improvement of environmental sanitation priority must be given to the provision of safe water and adequate disposal of human

Vaccination



Health Examination of School Children

Medical Examination of School Children
(Height and Weight)



Eye Examination of School Children

Health Education

Health Education

excreta. Arrangements for this will vary from area to area depending upon the local conditions and, as such, it is recommended that the District Medical Officer of Health of the area be consulted. He will supply the necessary plans, designs, etc.

Rural works in connection with drinking water are being executed by a variety of agencies and there is scope for better coordination. It is suggested that the District Health Officer and Public Health Engineering Department should draw up a comprehensive plan in consultation with District Planning Officer taking into consideration all the available funds in that particular district. Apart from the National Water Supply and Sanitation Programme and Community Development Budget, funds are available from other sources for this purpose. All these funds should be pooled for formulating a comprehensive scheme. The State Governments should have an organisation at the district level adequately staffed with trained personnel to initiate and execute plans for improvement of water supply and sanitation. The State Governments should also take advantage of the short-term courses in Public Health Engineering by deputing Assistant Engineers and Overseers to these courses. The Central Health Ministry is offering stipends for this training.

Drainage is an integral part of water supply and sanitation. Whenever a scheme for water supply is put up, adequate attention must be given to drainage. It has been noticed in the past that in a number of places where sanitary wells have been constructed or old wells sanitated, adequate attention has not been paid to the problem of drainage and water is permitted to stagnate around these wells creating insanitary conditions. Whatever the source of drinking water supply, it is necessary to take periodical samples for bacteriological examination. Simultaneously, arrangements should also be made for sterilization of drinking water. The District Health Officer will have to pay special attention to this aspect of the programme.

To control or minimise the high morbidity and mortality due to Gastro-intestinal diseases, something has to be done to stop soil pollution along with the supply of safe drinking water. For this purpose, it is necessary to develop a programme for construction of rural sanitary latrines. A satisfactory, cheap and acceptable pattern of water closet has been designed by the "action-*cum*-research" centres and approved by the All-India Association of Public Health Engineers. Details of the design are given in Appendix "D". It is recommended that sanitary latrines should be constructed in all the primary and secondary schools in the rural area and at other community centres. In addition to this, through education, individuals should be motivated to construct such latrines in their houses wherever space is available for the purpose. This programme has made good progress in a number of States. Unfortunately, programme for construction of rural latrines and urinals has not received the attention it deserves from the health workers.

(ix) Control of Communicable Diseases

Malaria eradication, control of filaria, leprosy, and B.C.G. are already in operation in the country under an all-India programme. Schemes for control of goitre and yaws are also in operation in those areas wherever these problems exist.

Recently the Union Ministry of Health have decided to establish Pilot Projects for mass treatment of Trachoma in the five States of Bihar, Uttar Pradesh, Punjab, Madhya Pradesh and Rajasthan. One Pilot Project will be located in a Community Development Block in each of the above mentioned five States where the survey reveals high incidence of Trachoma.

In 1959, the Union Ministry of Health appointed an Expert Committee to go into the question of control of small-pox and cholera. The Committee has already submitted its recommendations. In pursuance of the recommendations of this Committee, the Government of India has decided to start pilot projects for the mass eradication of small-pox in the country. These pilot projects will help the Government to work out details for a mass vaccination programme, *i.e.* requirements of lymphvaccine, staff, training, equipment, financial implications, administrative and supervisory details, etc. With this data in hand, the Government will embark on a nation-wide programme for small-pox eradication.

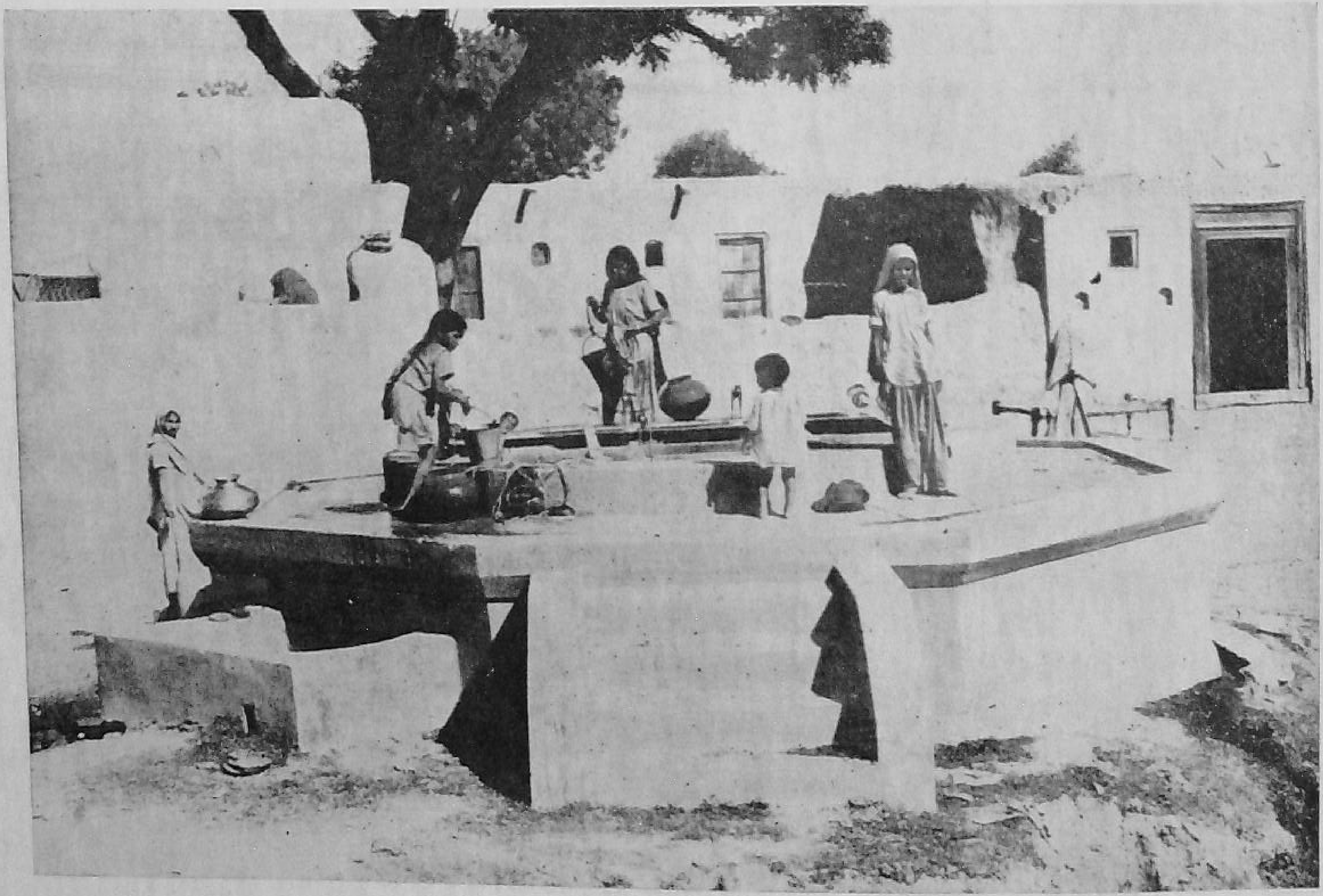
The above information is given to alert the health worker and other field workers in the Community Development Programme to be ready to give whatever assistance is possible in this programme. No programme for mass eradication of any disease can succeed without the active participation of the people and the Community Development workers are in an advantageous position to secure this participation.

(*x*) *Vital Statistics*

The staff should have accurate vital statistical data based on surveys conducted by the Department of Health or by other Departments. This will give a fairly accurate picture of health conditions present in the Development Block. On the basis of this, the Medical Officer in charge of the Primary Health Centre will be able to plan his future programmes. In fact, graphs and charts indicating vital health events and progress of health activities should be hung in the room of the Medical Officer. Further, during the course of their visits, the health staff may come across some specific cases of tuberculosis, leprosy, filaria, yaws, etc. Such discoveries will have to be followed up by a detailed survey under the guidance of the District Medical Officer of Health.

(*xi*) *Reports and Records*

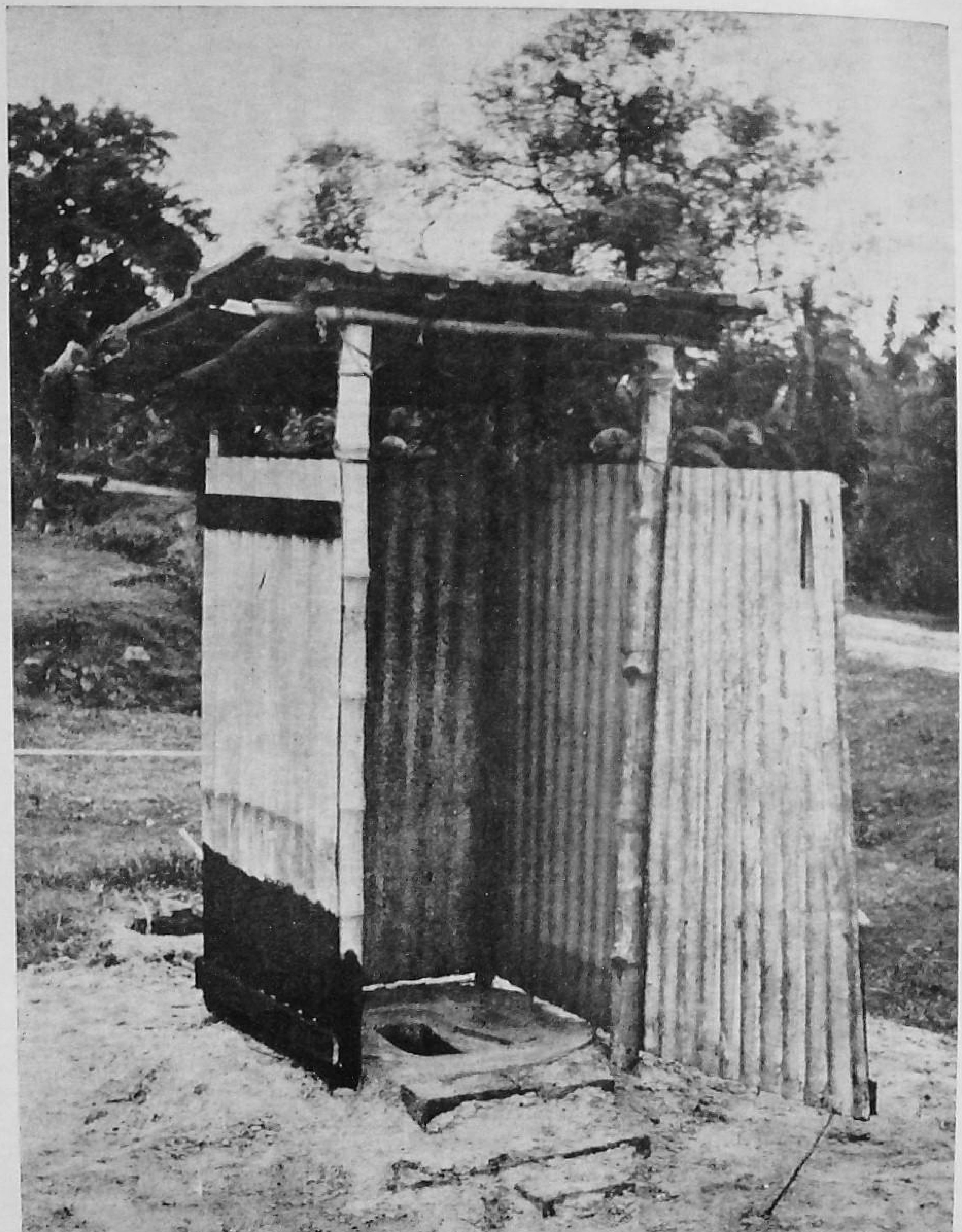
The importance of maintaining accurate records has not been fully appreciated by the health personnel including the Medical Officer at the Primary Health Centre. It is on the basis of these records that accurate reports and returns can be submitted to higher formations. Experience of the past few years has indicated that frequently clarifications have to be sought because of the discrepancies in the reports and returns. This creates unnecessary correspondence resulting in wastage of time and labour. It is suggested that the Administrative Medical Officers should issue clear instructions placing the responsibility on an officer in the District Health Organisation so that the reports are scrutinized carefully before submission to the State Headquarters for onward transmission to the Central Ministries.



Environmental Sanitation—An insanitary well

Environmental Sanitation—A sanitary well with two hand pumps and a lid with a handle in the centre of the cover of the well to facilitate drawing of water if both the hand pumps go out of order.

Environmental Sanitation—Hand pump for drinking water



Environmental Sanitation—Hand flush sanitary latrine

To stimulate interest in this subject, the District Health Officer should examine the records during his visit to the Primary Health Centre and discuss with the health workers the importance of such documents. In view of the heavy work-load the system of reporting should be reviewed and simplified.

7. National Health Programmes

National Health Programmes initiated by the Central Health Ministry on an all-India basis for eradication of malaria, control of filaria, leprosy, tuberculosis, etc. are being carried out by specialised units; these are in operation in those Blocks where such diseases are a problem. Later on, these special programmes will be integrated with health services of the Primary Health Centre for surveillance.

For effective change-over, the Administrative Medical Officer should consider the absorption of some of the existing staff employed in these national programmes with the present staff of the Primary Health Centre. He will also consider organising an inservice training of the existing health workers in some of these national programmes.

8. Referral Services

It is not sufficiently realised that the Primary Health Centre is not completely self-sufficient. It must depend upon the next higher level of health organisation and administration for certain specialised services and supervision.

There must be a liaison of health services between the Primary Health Centre and the referral hospital (Secondary Health Centre, taluk, *thana* or sub-divisional hospital) and the district hospital. For this purpose, it will be essential to develop diagnostic services at the referral hospitals—like X-ray and laboratory services and in addition, specialists services at the district hospitals where X-ray and diagnostic facilities are generally available. The State Health Departments will have to take early action to provide diagnostic facilities and specialist staff in those district hospitals where such services do not exist at present.

It is the duty of the Medical Officer in charge of the Primary Health Centre to arrange transportation of the patient to the referral hospital or district hospital as the case may be.

A number of Primary Health Centres have been provided with microscopes and have facilities for carrying out routine clinical laboratory examination of blood, sputum, urine, stool, etc. It is suggested that these facilities should be developed in every Primary Health Centre.

9. Transport

Transport has been provided as part of UNICEF assistance in most of the Primary Health Centres. Some State Governments have provided vehicles out of their own budget for the remaining Centres. The Medical Officer in charge of the Primary Health Centre should prepare a comprehensive tour programme in the Block, taking into consideration the duties of the Public Health Nurse/Lady Health Visitor and Sanitary/Health Inspector, so that,

maximum use can be made of the transport. Transport is very useful for implementation of the rural health programme, and, as such, it is necessary that servicing and garaging of the vehicles should be provided.

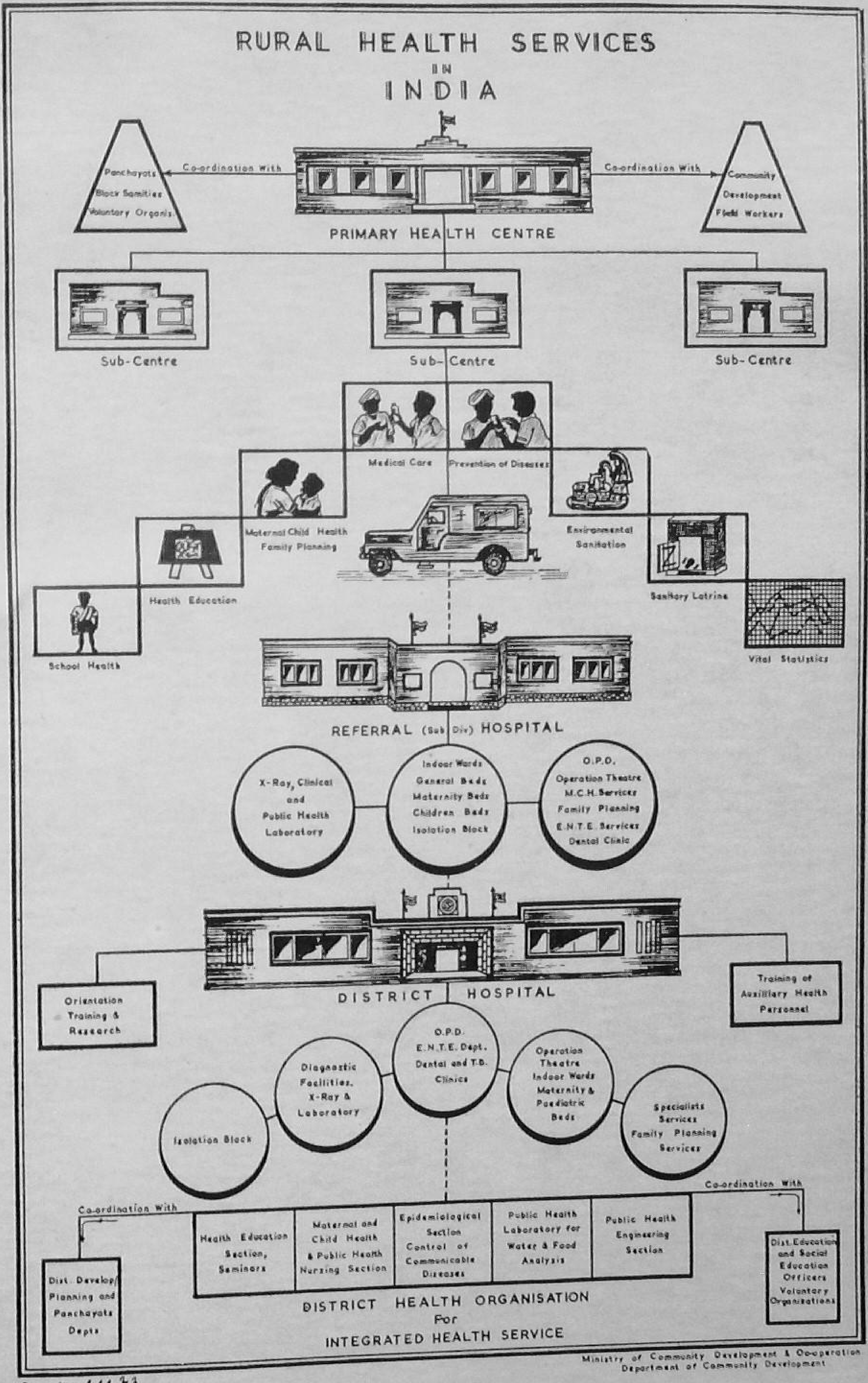
10. Administration and Supervision

For the effective development of integrated rural health services, it is essential that a single district health authority should be made responsible for the administration and supervision of the health programme in the district and to guide the Medical Officer and other health workers employed in this programme, if and when necessary. For this purpose, he should pay frequent and regular visits to the Primary Health Centres and sub-centres. His aim should be to analyse the work done, find out the weak points and remedy them. In addition, he should study the quarterly progress reports submitted by the Medical Officer in charge of the Primary Health Centre and take adequate action to bring the functions of the Centres to expected standards. This authority will also coordinate the health activities of the Centre with all other similar activities in the Block whether administered by local bodies or voluntary organisations like Social Welfare Board, Kasturbha Trust, etc. To do this effectively, the person chosen for these responsibilities should not be burdened with hospital administration and clinical work or permitted private practice and should possess public health qualifications and experience.

All the health staff including the doctor should be under the administrative control of this officer.

11. Role of the District Health Officer

In addition to the normal routine duties, the District Health Officer must be brought into intimate contact with all national health programmes like eradication of malaria, control of filaria and leprosy, B.C.G. and family planning, etc. After all, it is he, who is responsible for the uniform development of all health services in the district whether initiated by the State Government or the Central Government. It is suggested that the State Medical Officers in charge of the national programmes should channel all these programmes through the District Health Officer. In fact, before initiating a programme in a district, it would be helpful if details of planning and execution are discussed with the Health Officer of that district. The District Health Officer should maintain charts and graphs and other data indicating the progress of these special programmes in his office. This is essential because visiting officers from the State Headquarters or the Centre always contact the District Health Officer who has to provide comprehensive information on all aspects of health programme in his district. The District Health Officer is also in a position to help Medical Officers and auxiliary health personnel engaged in these national programmes in his district in case of any difficulty in the execution of the programme or break down of the vehicles and equipment. Finally, when these national health programmes have achieved the objective these will be transferred to the District Health Organisation for surveillance. As such, it is



Ministry of Community Development & Co-operation
Department of Community Development

Drawn by: [signature]

Domiciliary Medical Care

Delousing Operation

Inside of the Mobile Medical Unit

Mobile Medical units for rural areas

important that the District Health Officer should be kept in the picture from the very beginning. This procedure has been adopted in a few States with excellent results.

(i) Strengthening of District Health Organisation

To help the District Health Officer to carry out an effective supervision and to perform his duties efficiently, it is necessary that the question of giving additional staff should be considered. The existing staff position should be reviewed in the light of the added responsibilities. The need for a Public Health Nurse or a woman doctor with experience and qualifications in public health and maternal and child welfare and a Health Educator at the district level cannot be over-emphasised. It is essential to have an Assistant Public Health Engineer at the district level, if schemes for improvement of water supply and sanitation have to make a real progress.

(ii) Demonstration Districts

It is proposed to establish a "Demonstration District" in each State to make a study of the recent trends in comprehensive rural health service. The concept of integration of curative and preventive health care with emphasis on prevention started with the Community Development Programme. This study will help the State Governments to evaluate the impact of health services in the district and to evolve the standards of administrative and supervisory procedures, requirements of staff and their work-load and methods and techniques of training; also to develop methods for collection of vital and health statistics and for any other details essential to render effective health care to the rural people. To achieve these objectives, it will be necessary to implement the suggestions made earlier, *i.e.* the integration of the curative and preventive health services, appointment of a District Health Officer for administration of comprehensive health services in the district with the exception of district hospital and provision of additional staff to strengthen the District Health Organisation.

12. Co-ordination

This has to be achieved—

(i) Between the Curative and Preventive Health Services

The integrated health care with emphasis on prevention, necessitates that there should be full co-ordination of curative and preventive services at the district and block levels. This subject has been dealt with in some details earlier under the heading "Administration and Supervision".

(ii) Co-ordination with other Government Departments

Co-ordination with the Development Commissioner, Commissioner/Director of Panchayats and Director of Public Instructions at the State level by the Administrative Medical Officer and similarly at the district level by the various district officers of these Departments is very important for the success of this programme. The Development Commissioner is the coordinating authority for this

multi-purpose programme and is the key person in it. Similarly, the District Collector/Development/Planning Officer is the coordinating authority of all the district heads of different Development Departments. At the block level, the Block Development Officer has the responsibility to coordinate the activities of the various Development Departments; he is, or would be, the Chief Executive Officer of the Block Samiti and has to advise and guide in the functioning of the Panchayats. All the technical development officers and the Block Development Officer have thus to work as a team. As a technical officer, the Medical Officer in charge of the Primary Health Centre receives instructions from the District Health Officer or whoever is responsible for the health programmes in that area. It may be emphasised that whenever any local problems pertaining to lack of co-ordination arise at the block level, these should be settled mutually at the district level. As a result of the democratic decentralization the Commissioner/Director of Panchayats at the State level and his representatives at the district and block levels have to be brought into the picture more closely now.

To achieve our objective in health education a liaison with the Director of Public Instructions at the State level and the district educational authorities by our health workers is necessary so that a joint effort can be made for developing an efficient school health and school feeding programme. As the teacher has to play an important role in any programme for improving the health of school children, training him in health education is most vital and for this purpose, health education should be included in the syllabus of the Teacher's Training Courses.

Further, the field workers employed by the Development Department in each Block can also supplement our efforts in the health education of the people. Some salient points regarding the training and duties of these field workers are mentioned below to enable the health workers to secure their support in the promotion of health programme.

In each Block, there are 10 Gram Sevaks (Village Level Workers), 2 Gram Sevikas and 2 Social Education Organisers (one male and a female called Mukhya Sevika).

The Gram Sevak is primarily trained in agriculture, but receives intensive training in the extension technique for the multi-purpose Community Development Programme. Similarly, Social Education Organisers are specially trained to help—

(1) create healthy institutions to take up the programme and make it a people's programme. They specialise in developing people's organisations like the farmers' clubs, youth clubs, *Mahila Samitis* (women's clubs), health committees and help to provide these organisations with activities in which these groups can profitably participate;

(2) stimulate local leadership;

(3) organise community centres and gradually develop them as focal centres of social services and other amenities for the community.

In the light of the above, the success of acceptance and adoption of new ideas by the people will depend upon the support from these Social Education Organisers.

Gram Sevikas—They are trained in Home Economics. They have the advantage of easy access into the homes and, as such, are able to motivate the families for better health and better homes. Education of the family primarily means the education of the women, and it is the woman who is mainly responsible for the children and the home. Therefore, the need to educate women for effective participation in the all round development programme for improvement of health and the home becomes important and a pressing need.

All the above categories of field workers are given adequate training in the fundamentals of positive health, family planning, control of communicable diseases and improvement of environmental sanitation. This training is essential if they have to make effective contribution as health educators. As a matter of fact, experience has shown that these field workers carry a two-way message:

(1) They translate the health needs of the villagers to those responsible for the development of health programme; and

(2) Secure the participation of the villagers in the development of health programmes which are being initiated to meet the health needs of the people.

It may be stressed that Community Development is a coordinated team composed of both technical and non-technical persons working in the field.

It is the duty of the Administrative Medical Officers of the States concerned to arrange for adequate training of these workers in the subject of promotion of health and prevention of diseases. He can enquire from the Development Commissioner about the location of the training centres and particulars of the courses.

Certain specific diseases like filaria, leprosy, yaws, etc. are prevalent in some of the States. If possible, the Lecturer in Public Health at the Extension Training Centre in these States should arrange to show the Gram Sevaks a few cases suffering from these diseases. He should impress upon them the necessity for early treatment and control measures; the intention being that the Gram Sevak, during his routine visits to the villages under his jurisdiction, may be able to recognize the people suffering from these diseases and use his extension techniques to persuade them to avail of the treatment at the Primary Health Centre and to adopt control measures.

(*iii*) *Co-ordination with Local Bodies and Voluntary Organisations.*

In a number of Blocks, dispensaries, maternity centres and other health activities are being administered by local bodies and voluntary organisations like Social Welfare Board, Kasturbha Trust, etc. It is essential that the District Health Officer and the Medical Officer in charge of the Primary Health Centre should coordinate the

activities of the Primary Health Centre with the health activities of these various organisations working in the Block. This coordination is essential to avoid overlapping and for better coverage. Actually, the Medical Officer in charge of the Primary Health Centre under the guidance of the District Health Officer should provide direction for these groups and supervise their health activities. Most of these non-governmental organisations would welcome co-ordination and guidance because it is very seldom that they have an experienced technical officer on their staff for this purpose.

13. Panchayati Raj (Democratic Decentralization)

During 1959, an important development of very great significance took place. This is the programme of "Democratic Decentralization" whereby people's organisations are being developed at the village, block and the district levels, *i.e.* Panchayats, Block Samitis and Zilla Parishads. This development has given a new orientation to the programme and as a result of this a good deal of preventive health services, particularly improvement of environmental sanitation will have to be organised through these organisations. These organisations can also help in encouraging the people to accept immunisation and can also popularise family planning. This naturally adds greatly to the responsibility of the Health Department because they have to give greater guidance, supervision and help in the training of the personnel of these organisations for effective development of the health programme. This will gradually result in people's organisations taking over their rightful responsibility for promotion of health and prevention of diseases.

14. Training

For development of any programme, it is essential to have adequate number of trained personnel and this is more so in the field of the health programme, because of the special and extensive training required for the different categories of health personnel. The main problem has been lack of Public Health Nurses, Lady Health Visitors and Auxiliary Nurse Midwives. The chief difficulty is of recruiting a sufficient number of women with the minimum basic qualifications essential to undergo training. In spite of these difficulties, the State Governments have made a definite progress in augmenting the existing training facilities and establishing new training centres, but our requirements are far greater than the success achieved so far. This means that the State Governments should put forth greater efforts than ever to increase and improve their training programmes. It is suggested that training for Auxiliary Nurse Midwives be provided at the district hospitals where adequate facilities exist; the intention being to recruit women from the district and after training post them back to the same district. Experience has indicated that if adequate hostel accommodation is provided, more girls would be prepared to take up this type of training.

All training centres should maintain a close liaison with a nearby Community Development Block so that the trainees can utilize the Primary Health Centre and sub-centres as rural practice field.

(i) Need for Training of Teaching Staff

To cope with increasing number of trainees and training centres, it is necessary that the State Governments should take immediate steps to train a good number of Public Health Nurses and sister-tutors to take up positions as teachers at the training centres. For all the training programmes substantial financial assistance is being offered by the Union Ministry of Health.

15. Orientation Training

(i) For Primary Health Centre Staff

To achieve the goal of integrated health care and in view of the special nature of the Community Development Programme, it was considered essential that doctors and other health workers posted at the Primary Health Centres should receive special orientation in the basic philosophy and concept of this programme and get training in the new technique of extension, so that they can work as a team and are able to secure people's participation in the programme. The effectiveness and quality of service depend upon the attitude and the efficiency of the staff. The doctors and other health workers must be trained to understand the problems of human beings and taught the ways of working with human beings, with communities and organisations of human beings. This orientation is necessary as most of the doctors and health workers have been trained in urban areas and in urban environments. For this purpose, the Union Ministry of Health with the aid of Ford Foundation has established three Regional Orientation Training Centres at Najafgarh, Singur and Poonamallee. Unfortunately, some of the States could not take full advantage of these Centres; primarily because of shortage of personnel and lack of training reserve. Greater advantage is being taken of these facilities now and in addition, some of the States have started a short course in orientation for their health personnel.

(ii) For District Health Officer and other Senior Supervisory Officers

The District Health Officers and other senior staff charged with the responsibility of supervision should also receive orientation in this multi-purpose Community Development Programme and get training in methods and techniques of supervision.

(iii) Need for Additional Training Centres

Since the Community Development Programme is fast expanding, it is essential that each State Government should establish Orientation Training Centre of its own in addition to making use of seats allotted in the three Regional Orientation Training Centres at Najafgarh, Singur and Poonamallee. It will be necessary to develop one or two existing Primary Health Centres in suitable districts for this purpose and to provide teaching staff, quarters for the staff and hostel for the trainees. This inservice orientation should not be confused with the rural training for the internees which is being carried out at the Rural Health Units in association with the Chair of Preventive and Social Medicine of the medical colleges in some States.

It is expected that all the medical colleges will establish a Chair of Preventive and Social Medicine during the Third Five-Year Plan period and will also develop Rural Health Units, so that every young doctor is equipped with the new orientation as soon as he takes his university degree. It is essential that these Rural Health Units should be located in Community Development Blocks.

16. Research and Evaluation

(*i*) *Research*

Primary Health Centres offer good opportunities for studies and research in administrative patterns, work load of the staff and in different aspects of health problems. Some of these Primary Health Centres can be developed as "research-*cum*-action" centres on the pattern of the three Regional Centres that have been established at Najafgarh, Singur and Poonamallee. As a result of research, it will be possible to establish criteria for a number of points related to rural health services. To achieve this objective, additional staff and workshop facilities will have to be provided. Some studies on the lines suggested above are going to be carried out at "The Gandhi Gram Pilot Health Project" which was established in 1959.

(*ii*) *Evaluation*

To find out the impact of the health services provided by the Community Development Programme, it is necessary to evaluate the results of our efforts. At the time of establishment of the Blocks, certain surveys were carried out which brought out some useful data. It would be interesting to conduct fresh surveys after the services have been in existence for a minimum period of five years to find out what improvements have taken place since the last survey and what is the impact of integrated health services on the morbidity and mortality of the area in relation to particular diseases and epidemics. It will also be interesting to find out to what degree the villagers have changed their attitudes and habits as a result of health education. The evaluation will indicate if our methodology of approach has been effective.

It is realised that it will take some time before we are able to establish research and carry out evaluation, but these matters should be borne in mind from the very beginning and should form part of the long-term planning.

17. Staff Conferences

It is suggested that the District Health Officer should hold a staff conference every six months with Medical Officers and other health workers of all the Primary Health Centres in his district. The District Planning Officer, Block Development Officers and one or two Gram Sevaks, Social Education Organisers and Mukhya Sevikas should be requested to participate in the conference. These conferences will be most useful for the promotion of health programme and for the solution of a number of day-to-day problems. Further, the conference will help bring about a better team spirit and coordination between the Health and the Development Departments.

The Medical Officer in charge of the Centre should also arrange to hold regular staff meetings, once a month with all his staff. These meetings, if possible, can be arranged on the same day immediately after the Block Development Committee meeting. Such meetings are bound to achieve better "working conditions". They are very essential for personnel morale and to make each member feel that he is a part of the organisation. It may be emphasised that it is the duty of the health staff to view the problem of health in its entirety without taking a narrow view of the relative duties and responsibilities. It is a team work for development of better health and creation of healthful environments in which all field workers should participate.

18. Seminars

The Department of Health in each State should organise annual seminars on "Rural Health" and invite representatives of the Departments of Development, Panchayats and Education to participate in the discussions. Some of the actual field workers must be invited so that they can bring forward their experience and their problems before the participants. These seminars may be organised at the district or the regional (divisional) level to enable greater participation by the field workers. They can be followed by a seminar at the State level.

19. Budget

Certain funds for health services have been provided in the schematic budget for each Block. These funds are for capital expenditure, for the construction of Primary Health Centre and sub-centres and for purchase of equipment, furniture, etc. and for recurring expenditure for staff, drugs, dressings, etc. The State Governments have to share this expenditure on the basis of 25 per cent on the capital cost and 50 per cent for the recurring expenditure. In addition, popular contribution from the people in the form of donations of land for the construction of Primary Health Centre and sub-centres and also some cash contribution towards the cost of construction are generally available. It may be stated clearly that the Community Development funds are only nucleus funds designed to stimulate local participation and to supplement the budget provision of the State Health Department.

In addition, since 1st April, 1958, the Union Ministry of Health has provided Rs. 52,500 for every Primary Health Centre established after this date. Thus, the total Central provision for construction of buildings for the Primary Health Centre and three sub-centres and residential quarters for the staff comes to Rs. 60,000 (Rs. 52,500 plus Rs. 7,500 from the Ministry of Community Development). The State Government has to provide a sum of Rs. 20,000 (25 per cent of its share) as the total estimated cost of construction comes to about Rs. 80,000. The cost of equipment, recurring expenditure for staff, drugs and dressings, etc. is shared equally between the Ministry of Community Development and Cooperation and the State Government.

20. Literature

It is suggested that some standard text books and reference books on medical and public health subjects should be stocked in each

Primary Health Centre. As part of UNICEF assistance, some books for reference purpose have been supplied to those Centres which were included in the "Plan-ops". Further to help the Medical Officer to keep up-to-date with the latest developments in the field of medical and public health, a few journals should be subscribed to by the District Health Officer and circulated to all the Primary Health Centres.

21. Equipment and Furniture

A list of equipment and furniture is given in Appendix "B". This is only a suggestive list and the Administrative Medical Officers are at liberty to amend these lists to suit local requirements.

22. UNICEF Assistance

Since the beginning of the Second Plan UNICEF has come forward with aid for intensification of health services in the Community Development areas. UNICEF concluded a "Plan-op" with individual States giving details of the aid and laid down criteria in consultation with the Union Ministry of Health and the World Health Organisation for the release of this assistance. Before finalizing the "Plan-op", the representatives of the UNICEF visited each State and worked out the requirements for assistance in consultation with the State Health Department. The aid consists of medical, surgical and diagnostic equipment for Primary Health Centres, referral hospitals and for strengthening of public health laboratories and a vehicle each for every Primary Health Centre and District Health Officer. Assistance for training of personnel in the form of teaching aids, cycles, school buses and equipment and stipends for the trainees were also made available. Further, UNICEF has agreed to supply equipment for improvement of environmental sanitation for a limited number of primary schools adjoining the Primary Health Centres in each State. The aid has proved most useful and we are very thankful to UNICEF and WHO.

APPENDIX "A"

DUTIES

Medical Officer

1. The Medical Officer will be responsible both for curative and preventive health work. He will, therefore, not only attend to the clinic and the wards, but also supervise the work of the public health staff working in the villages in the block. In case of any serious cases which need specialised care, he will arrange to transport such cases to the hospital where those facilities are available.
2. He will tour the area to organize, direct and control different health activities.
3. He will visit a certain number of villages in the afternoon to render medical aid.
4. He will carry out health survey of the villages with the help of sanitary/health inspector and village level workers.
5. He will prepare advance programme of visits to villages for all the personnel working under him.
6. He will arrange for collection and maintenance of vital statistics and other records.
7. He will prepare indents for drugs, dressings, etc.
8. He will prepare and submit periodic returns as instructed by the Administrative Medical Officer of the State concerned.
9. In case of threatened epidemic, he will immediately contact the District Medical Officer of Health and render help in the control measures.
10. He will attend the meetings of the Block Advisory Committee and maintain a close liaison with other extension workers particularly the social education organiser.
11. He will arrange for the health education work in the area. For this, he will procure education material from the District Medical Officer of Health and make the best use of it through his sanitary/health inspector, education authorities and social education organizer.
12. He will be responsible for the development of school health programme and medical examination of school children and try to get the defects, if any, corrected.
13. He will maintain an inventory of all the equipment, medicines, surgical instruments, linen, furniture, etc. and check the inventory at specified periods.

Lady Health Visitor/Public Health Nurse

1. She will be responsible for the development of maternal and child health services in the block.
2. She will conduct ante-natal clinics, and well-baby and toddlers' clinics at the primary health centre and at the sub-centres.

3. She will arrange to give group talks to expectant mothers. During these talks she will lay stress on personal hygiene, nutrition and environmental sanitation.
4. She will carry out 'home visits' when not conducting clinics at the primary health centre or the sub-centres. During these visits in addition to giving advice about maternity and child health, she will demonstrate simple procedure to relieve conditions such as lousiness, scabies, sore eyes, etc.
5. She will visit once a week on fixed days each of the three maternity sub-centres. During these visits, she will conduct ante-natal and well-baby clinics.
6. She will advise on Family Planning.
7. She will observe and supervise the work of the midwives/auxiliary nurse midwives and dais. For this purpose, it will be necessary for her to observe them conduct one or two deliveries in the homes.
8. She will observe the midwife/dai during the clinic session and help her improve her technical and human relationship skills.
9. She will respond to an urgent call from the midwife/auxiliary nurse midwife/dai.
10. She will scrutinize and approve the order for supplies and equipment by the mid-wives/auxiliary nurse midwives.
11. She will ensure that ante-natal and post-natal cards are maintained for mothers, and infants and toddlers' cards for the children.
12. She will be responsible for maintenance of records, preparation and submission of reports and returns.
13. In abnormal cases, she will arrange for the transport to take expectant mothers to the hospital.
14. She will see that adequate equipment is provided and maintained for maternity and child care.
15. She will help in the training of indigenous dais.
16. She will help in the development of school health programme and assist medical officer in the medical examination of girl students.
17. She will hold staff conferences with the midwives and dais once a month.
18. She will give an evaluation report of the work done in the field of maternal and child health.
19. She will maintain an inventory of all the equipment, instruments, furniture and other articles required for maternity and child welfare work and check the inventory at specified periods.

Midwife/Auxiliary Nurse Midwife

She will work under the overall supervision of the lady health visitor. She will try to gain the confidence and cooperation of the people where she is working. She will take particular care to make friends with the local untrained dais and encourage them to come to the Centre and train them

in better methods and techniques in conducting deliveries. She should even accompany the local dais when they go for conducting labour cases in homes. There will be a number of cases who, even though, have been receiving ante-natal care at the Centre, will probably send for the local untrained dai at the time of delivery. In such cases, the midwife/auxiliary nurse midwife should not hesitate to pay post-natal visits to mothers. Her duties are:

1. In addition to carrying out domiciliary midwifery during home visits, she will contact expectant mothers and encourage them to come to the Centre.
2. She will help the Public Health Nurse/lady health visitor on days of her visit to the Centre for clinics.
3. She will keep records of her work and submit returns as and when asked for.
4. She will help in the training of indigenous dais.
5. She will take part in health education programme during home visits and when mothers come to the Centre.
6. She will maintain a register of all the equipment and other materials supplied to her.

Sanitary/Health Inspector

He will work under the general supervision of the medical officer in charge of the primary health centre. His duties are:

1. He will assist the medical officer in carrying out health surveys of the villages in the block.
2. On the basis of the survey, the medical officer will plan out a programme and the sanitary inspector will be responsible for its execution.
3. He will collect and consolidate vital statistics and submit returns to the medical officer.
4. He will be in charge of the overall environmental sanitation programme in the block.
5. He will help in the supervision and construction of wells, rural latrines and urinals, smokeless chullas (Magan Chulla), soakage pits, pavement of streets, etc. For this purpose, the sanitary inspector must be in possession of 'Blue-prints' of all the above items which can be procured from the District Medical Officer of Health of the area.
6. During his tours, he will visit schools for looking into the environmental conditions. He will also arrange to give health talks in these schools.
7. He will carry out all measures for the control of communicable diseases under the instructions of the medical officer, *i.e.*, immunisation against smallpox, cholera, plague, etc. and disinfection of wells and homes, when necessary.
8. He will undertake control measures against fly and mosquito nuisance and will be responsible for spraying of residual insecticides. In fact he will be responsible for all vector control in his area.

9. He will bring to the notice of the medical officer cases of leprosy, tuberculosis, filariasis, yaws, if any, and take measures for their isolation and treatment as directed by the medical officer.

10. He will carry out health education programme in the block and will seek the assistance of the village level workers, social education organiser and school teachers in this programme.

11. He will carry out health education programme at all *melas, yatras*, etc. In fact he will take advantage of any gathering of the people any where in his block.

12. He will procure health education material like posters, leaflets, pamphlets, cinema slides, flash cards, etc. from the District Medical Officer of Health through the medical officer in charge of the primary health centre.

13. He will maintain a stock ledger concerning his section, *i.e.* for all the furniture, equipment and other materials received from the medical officer.

14. He must gain the confidence, cooperation and participation of the people in the block if he has to make a success of his job.

15. He will maintain close liaison with the social education organiser and village level workers who can help him considerably in all his duties. The village level worker is in close touch with the villagers and is in a position to interpret the 'felt-needs' of the people in the field of environmental sanitation.

16. He will organise village health committees and maintain close liaison with other voluntary organisations that may be present in his area with a view to securing their assistance in the execution of his programme.

APPENDIX "B"

LIST OF EQUIPMENT FOR A PRIMARY HEALTH CENTRE

Consultation and Diagnosis

Medical Officer's Consulting Room

1.	Examination table (Metal)	1
2.	Instrument tables (Metal)	2
3.	Scales adult, with height stand	1
4.	Scales, infant	1
5.	Sterilizer, small instrument, stainless steel 13″×5″×4″ for use over kerosene or charcoal stove	1
6.	Refrigerator, kerosene operated 5 cu. ft. electrolux or similar	1
7.	Eye charts-Snellen, E type	2
8.	Hemoglobin scales, Tallquist	2
9.	Stethoscope	1
10.	Percussor hammer, hard rubber	1
11.	Sphygmomanometer	1
12.	Oto. opthalmic set	1
13.	Pelvimeter	1
14.	Tongue depresser, metal, set of 3, varied sizes	1
15.	Speculum vaginal small bi-valve	1
16.	Speculum, Nasal—stainless steel	1
17.	Syringes, hypodermic 2 cc	2
18.	Syringe, hypodermic 10 cc	1
19.	Syringe, ear—metal	1
20.	Needles, hypodermic 24 g×1″	6
21.	Needles, hypodermic 22 g×1½″	6
22.	Thermometers clinical, mouth	2
23.	Mirror mouth	1
24.	Torch electric	2
25.	Bowls	2
26.	Tray—kidney shape	1
27.	Jars	2
28.	Bucket	1
29.	Tourniquet	1
30.	Tape, Measuring	1

Laboratory

1.	Microscope monocular, mechanical stage, optics for magnifications 50×97	1
2.	Urinometer	1
3.	Hemoglobinometer, Sahli	1
4.	Hemacytometer	1
5.	Centrifuge, hand operated, 2 tube type	1
6.	Centrifuge tubes	1
7.	Clini-test, laboratory type (for testing sugar in urine)	1
8.	Test-tubes 6″×1″	2 doz.
9.	Test-tube clamps	3
10.	Microscope slides	2 doz.
11.	Bottles, glass stoppered (for lab. chemicals 8 oz. size)	4
12.	Bottles, dropper type, 2 oz.	4
13.	Bottles, urine specimen	1 doz.
14.	Test-tube rack, 6 place, white enamel	1
15.	Test-tube brush	2
16.	Burner, alcohol, 4 oz.	1
17.	Burner wicks for above	12
18.	Spirit lamps	3
19.	Flask glass conical	6
20.	Glass rods	6
21.	Funnels, pyrex glass	2
22.	Sterilizer, instrument, size 13″×5″×4″ stainless steel	1
23.	Sharpening stone	1
24.	Bowl solution, stainless steel 6″	2
25.	Stove primus	1

Dispensary

1.	Sterilizer, white enamel 18″×8″×5″ use over kerosene or charcoal stove	1
2.	Graduated measure glass, 6 oz.	2
3.	Graduated measure glass, 8 oz.	2
4.	Graduated measure, stainless steel, 1 pt.	1
5.	Funnels, pyrex glass, varied sizes	3
6.	Bottle brushes	2
7.	Funnel, stainless steel	1
8.	Slab ointment, graduated 8″ size	1
9.	Stirring rods, glass	4
10.	Spoons, 10″	2
11.	Scales, dispensing, pharmacist, with weights, etc. complete	1
12.	Pestle and mortar, standard size	1
13.	Funnel, pyrex glass 4/7/8″	2
14.	Funnel, stainless steel 4/7/8″	2
15.	Spatula for mixing ointments and powders	1

16.	Medication bottles, glass stoppered wide mouthed (32 oz.) capacity	8
17.	Soap dish, stainless steel	1
18.	Receptacle, waste steel removable basket step on	2
19.	Mini-measure, glass, one oz. size	3
20.	Scissors ordinary	1

Surgical and Labour Rooms

1.	Dental extracting forceps, set of 3 stainless steel varied type and size	1
2.	Mirror, head, 3½ dia. glass with head band	1
3.	Forceps, hemostatic straight, stainless steel	3
4.	Forceps, hemostatic curved, stainless steel	3
5.	Forceps, Obstetric	1 set
6.	Forceps, sponge, stainless steel	2
7.	Forceps, tongue, stainless steel	2
8.	Forceps, tissue	2
9.	Trays kidney shape	2
10.	Tray instrument, stainless steel	2
11.	Rubber sheet	4 yds.
12.	Forceps, vulsellum, straight, stainless steel	2
13.	Forceps, dressings, stainless steel	2
14.	Knives, operating, stainless steel	2
15.	Scissors, bandage, stainless steel	2
16.	Scissors, gauze, stainless steel	1
17.	Scissors, surgical, stainless steel	2
18.	Speculum, vaginal bi-valve, medium, stainless steel	1
19.	Retractors, vaginal 3″, stainless steel	2
20.	Needle holders, stainless steel	1
21.	Syringes, hypodermic, 2 cc.	4
22.	Syringes, hopodermic, 10 cc.	3
23.	Needles, hypodermic 24 g× 1″	4
24.	Needles, hypodermic 22 g× 1½″	3
25.	Needles, infusion	3
26.	Catheter urethral, male, metal sizes 16 and 18 French	2
27.	Catheter, female, metal size 12, French	1
28.	Catheter, rubber, two dye, solid tips, small medium large	3
29.	Droppers, medium, bent	24
30.	Eye wash glasses	2
31.	Kit-suture assortment, sterile sutures, with needles 2 with 3/8 circle needle, 2 with ½ curve needle	4
32.	Pencils, skin marking black	2
33.	Mask, anaesthesia	1
34.	Thermometers clinical, mouth	4
35.	Thermometers clinical, rectal	6

36.	Gloves surgical, size $6\frac{1}{2}$	6
37.	Gloves surgical, size $7\frac{1}{2}$	6
38.	Sheeting plastic, 36″ wide	3
39.	Finger cots, reinforced	4 doz.
40.	Operation table (field type)	1
41.	Enamel stools, revolving	2
42.	Instrument table, metal covered (medium size)	2
43.	Pressure, sterilizer with stove and drum, stainless steel type with hooks, gauges, etc.	1
44.	Soap dish, stainless steel	1
45.	Sponge bowl, 4″, stainless steel	6
46.	Tray, instrument, covered $6\times 3\frac{1}{2}\times 2$, stainless steel	3
47.	Jars, dressing, stainless steel	4
48.	Bag, obstetrical for the doctor	1
49.	Aspirator, nasal, infant size	1
50.	Pump breast	1
51.	Stove Primus	1
52.	Bowls	4
53.	Sterilizer instrument	1

Ward

1.	Enema can, stainless with handle	1
2.	Tubing for enema can	12 ft.
3.	Nozzle hard rubber infant	2
4.	Nozzle hard rubber adult	2
5.	Syringe infant-enema bulb type	1
6.	Sheeting plastic 36″ wide	3
7.	Connection glass to fit enema-can	4
8.	Clamp for enema-can nickel plated	2
9.	Basin kidney, stainless steel 6 ft.	6
10.	Themometers, clinical	12
11.	Hot water bottles	2
12.	Ice bags	2
13.	Instrument table (medium size)	1

Family Planning

1.	Instrument tray with cover	1
2.	Bowls of different sizes	4
3.	Dressing drum	1
4.	Sterilizer, white enamel 18″×8″×5″ use over kerosene or charcoal stove	1

5. Primus Stove	1
6. Kidney trays	2
7. Forceps (Luces)	1
8. Forceps (Dissecting)	2
9. Forceps (Ordinary)	2
10. Scissors (Straight)	1
11. Scissors (Curved)	1
12. Vaginal Speculum (Large & Small)	2
13. Thermometers	2
14. Sauce Pan	1
15. Kettle (brass)	1
16. Torch	1
17. Rubber Gloves	3 pairs
18. Finger stalls	1 doz.
19. Rubber models of female parts	1
20. Urine testing apparatus	1

FURNITURE

Consultation Room

1. Examination table 72″×30″×36″	1
2. Office table with drawers	1
3. Office chairs with arms	4
4. Side tables	2
5. Towel rack	1
6. Stools wooden	2
7. Stool revolving	1
8. Benches wooden	3
9. Screen	1
10. Racks wooden	2
11. Trays wooden	2
12. Wash-hand stand complete with E.I. Basin, Jug and soap dish	1

Dispensing

1. Dispensing table with zinc top and counter	1
2. Almirahs 7′×4′×2′	2
3. Stools	2

Dressing and Minor Surgery Room

1.	Operation table ordinary	1
2.	Screen folding	1
3.	Dressing trolly	1
4.	Table dressing	1
5.	Teapoys	2
6.	Stools	2

Waiting Room for Patients

1.	Benches	6

Office and Record Room

1.	Almirahs large wooden 7′×4′×2′	3
2.	Teapoy	1
3.	Stools	2
4.	Office table with drawers	1
5.	Chairs	2
6.	Trays	2
7.	Waste Paper Basket	1

Maternity and Child Welfare Room

1.	Office table with drawers	1
2.	Chairs with arms	2
3.	Stools	4
4.	Examination table 72″×30″×36″	1
5.	Foot-step for table	1
6.	Wash-hand stand complete with E.I. Basin, Jug and soap dish	1
7.	Rack wooden	1
8.	Small tables	2
9.	Almirah	1
10.	Card boxes	2

Family Planning Room

1.	Office table	1
2.	Chairs	2
3.	Teapoys	2
4.	Stools	2
5.	Examination table	1
6.	Towel rack	1
7.	Wash-hand table, basin and Jug	1 set
8.	Soap dish	1
9.	Waste receptacle E.I.	1

10. Foot stool	
11. Rubber sheet	4 yds.
12. Almirah	1
13. Card Index Cabinets	2

Ward

1. Beds	6
2. Bed-side lockers	6
3. Almirah medium size $6' \times 3\frac{1}{2}' \times 1\frac{1}{2}'$	1
4. Stools wooden	6
5. Screens wooden	2
6. Tables small wooden $3' \times 2' \times 2\frac{1}{2}'$	2
7. Office table with drawers	1
8. Towel stands	4
9. Wheel chair	1
10. Table dressing	1
11. Instrument and dressing trolly	1
12. Screen folding for ward	1
13. Wash-hand stand complete with E. I. Basin, Jug and soap dish	1
14. Chart holders	6
15. Dust bins with lids	4
16. Commodes complete	2
17. Hamams for heating water	2
18. Face Mirror	1
19. Tubs (2-maund capacity)	2
20. Stand for douche enema	1
21. Foot mats	6
22. Stretcher	1
23. Water buckets	2

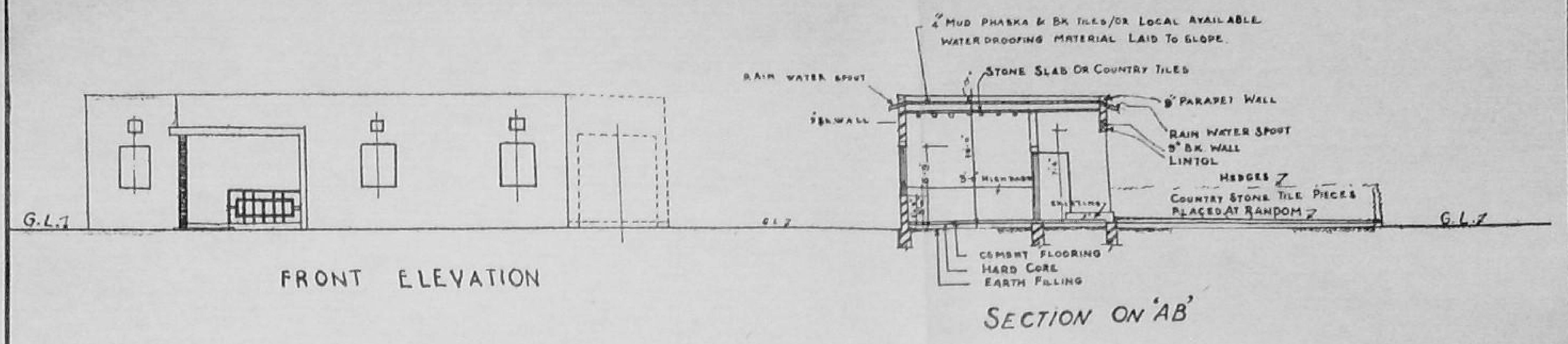
Duty Room

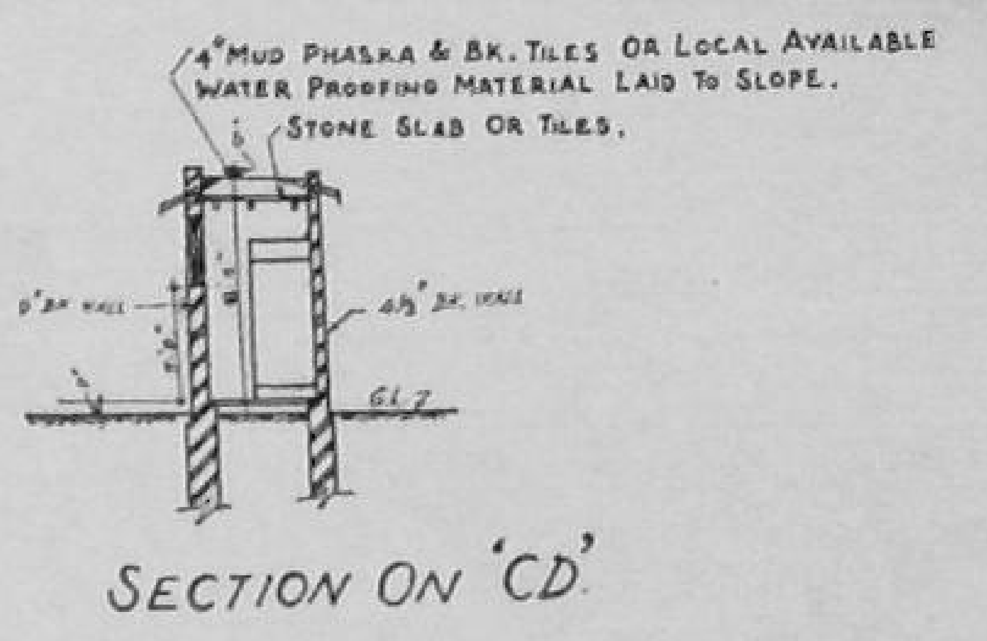
1. Office table with drawers	1
2. Office chair with arms	1
3. Side racks	2
4. Steel wooden	1
5. Almirah larg wooden $7' \times 4' \times 2'$	1
6. Cupboard for medicines medium size	1
7. Meat safe	1
8. Wash-hand stand complete with E.I. Basin, Jug and soap dish	1
9. Towel stand	1
10. Teapoy	1

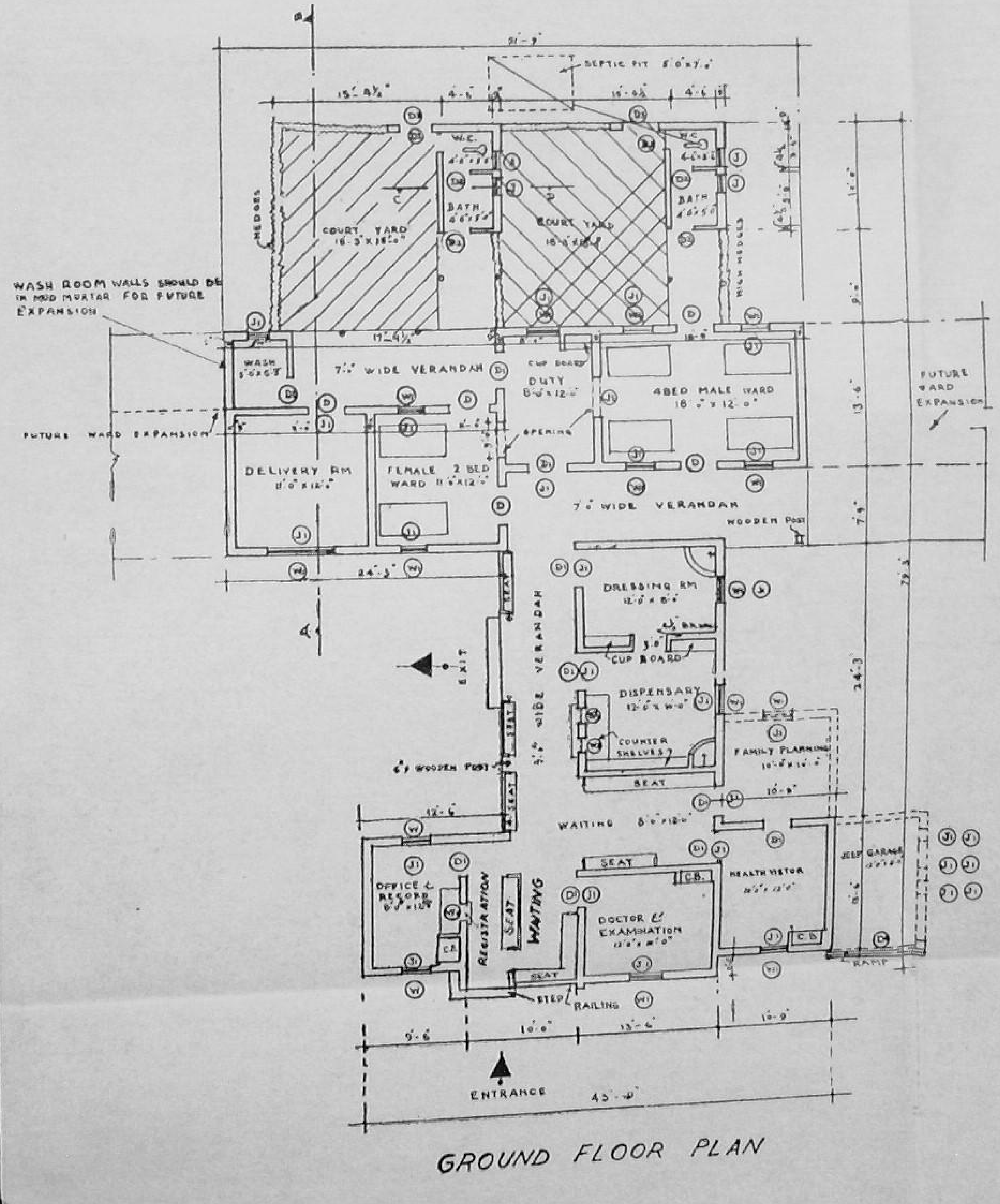
Labour Room

1.	Table, obstetric with necessary leg fittings, etc.	1
2.	Side table for keeping instruments	1
3.	Table metal shape	1
4.	Buckets E.I.	2
5.	Wash-hand table, basin jug	1 set
6.	Towel rack	1
7.	Buckets receptacle	2
8.	Cupboard (small)	1
9.	Tub (small) for washing baby	1
10.	Wooden screen	1

APPENDIX "C"







SCHEDULE OF DOORS, WINDOWS AND JALIS

Type	Size	Description	Nos.
D	3'-6"x6'-9"	DOUBLE HUNG FRAMED & BATTENNED	5
D¹	3'-3"x6'-9"	SINGLE HUNG FRAMED & BATTENED	8+2
D²	2'-6"x5'-6"	SINGLE HUNG LEDGED & BRACED ON PIVOT AT 6" HIGH FROM FLOOR LEVEL WITH OUT FRAME	6
D³	3'-3"x6'-0"	SINGLE HUNG LEDGED & BRACED ON PIVOT WITH OUT FRAMES.	2
D⁴	8'-0"x8'-0"	DOOR DOUBLE HUNG FRAMED & BATTENED	+1
W	2'-6"x3'-9"	SINGLE HUNG GLAZED	2
W¹	2'-9"x3'-9"	SINGLE HUNG GLAZED	11+1
W²	3'-0"x5'-0"	DOUBLE HUNG GLAZED	1
W³	2'-0"x2'-6"	DOUBLE HUNG PANELLED	3
J	1'-6"x3'-0"	COUNTRY MADE JALI	5
J¹	15"x15"	COUNTRY MADE JALI	20+8

	PLINTH AREA	APPROX. COST
MAIN BUILDING	2,430 SQ.FT.	RS. 15,650/-
" " INCLUDING FAMILY PLANNING & GARAGE	2,430+235 = 2,665 SQFT.	RS. 17,160/-

NOTES:-

DRAWING REVISED ON 9.9.58 SHOWS THE ADDITION OF GARAGE & FAMILY PLANNING ROOM IN DOTTED.

DESIGN FOR A RURAL HEALTH CENTRE
(Flat Roof)

DRG. No. ST/89

Scale 8'-0" To 1"

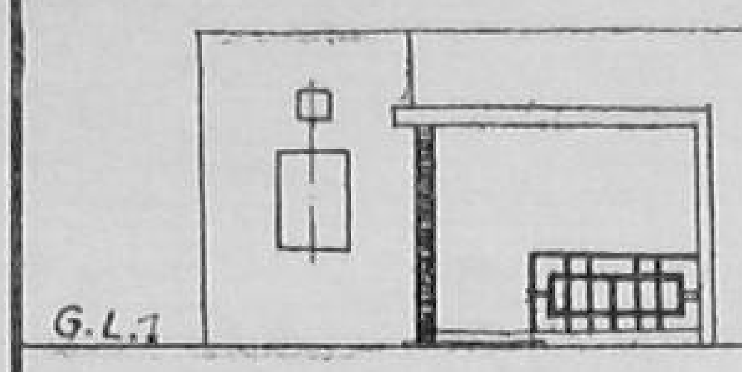
DRAWN BY: G.C. Malik.
TRACED BY: K.N. Sharma.
CHECKED BY: [illegible]

DATE
DRAWN:- 30.3.58
TRACED:- 19.8.60

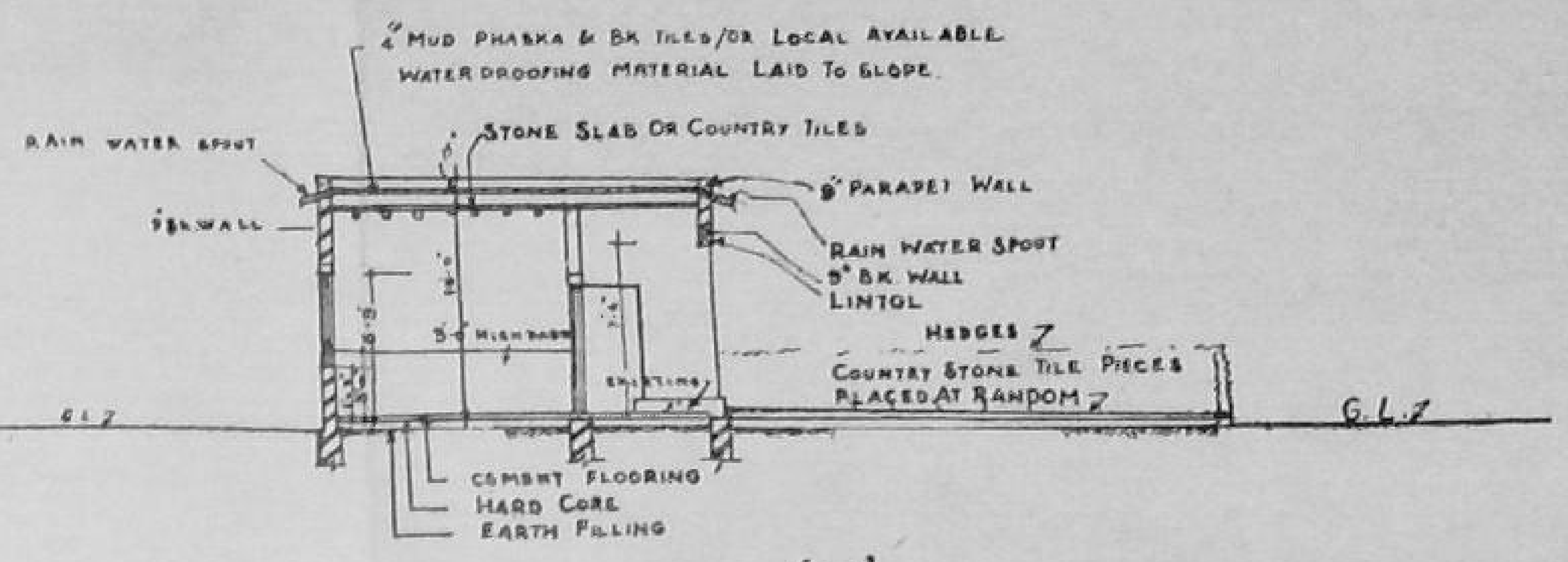
Sd/-
D. ARCH
ASSTT ARCHITECT

Sd/-
A.R.I.B.A., A.I.I.A
SENIOR ARCHITECT

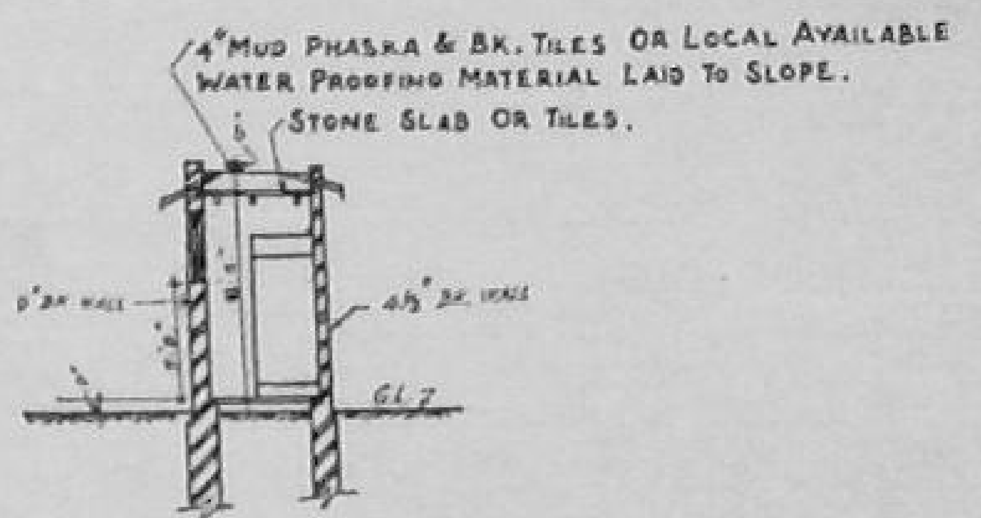
ARCHITECTURAL SECTION
D.G. of H.S.
NEW DELHI.



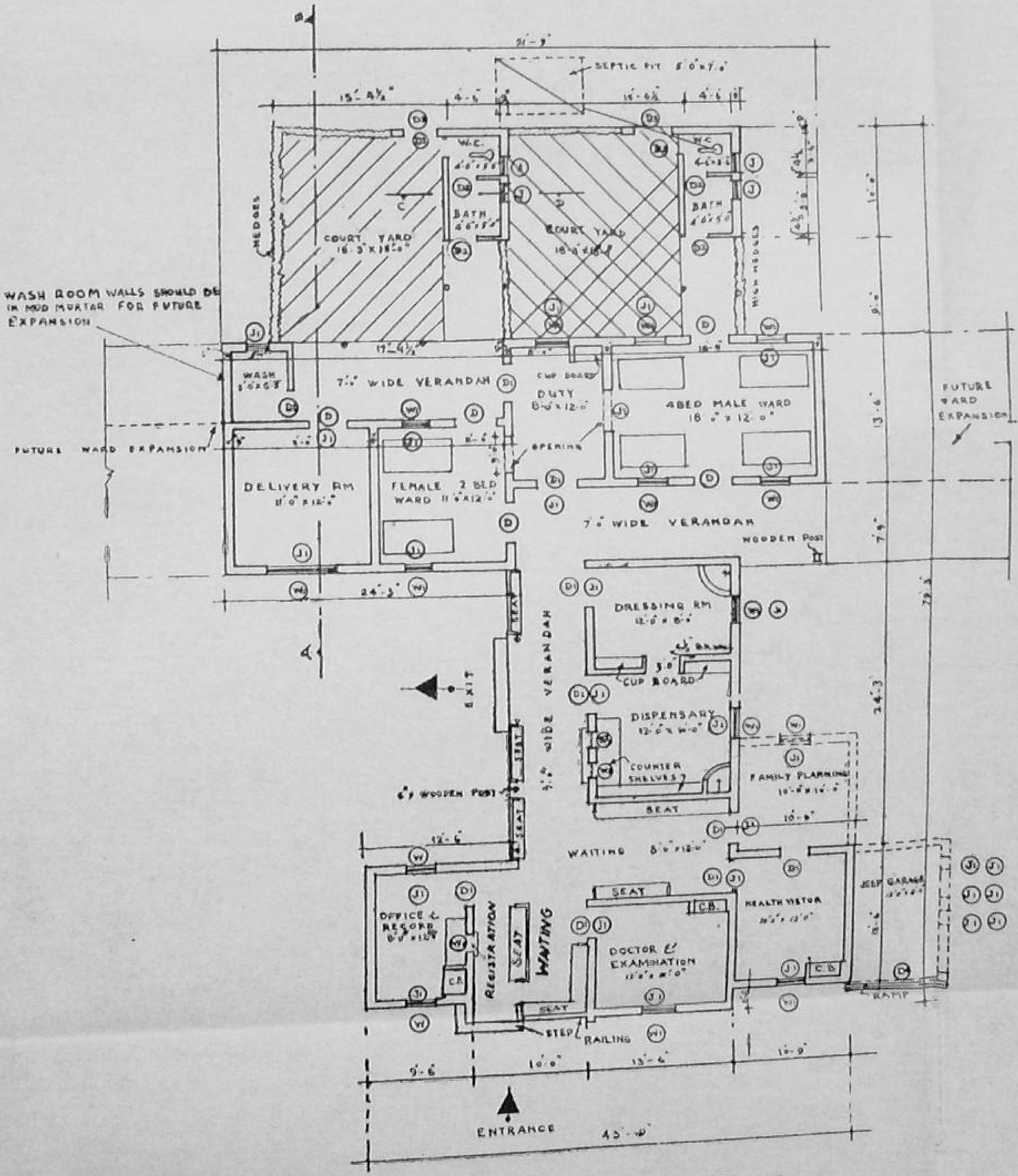
FRONT ELEVATION



SECTION ON 'AB'



SECTION ON 'CD'



GROUND FLOOR PLAN

SCHEDULE OF DOORS, WINDOWS AND JALIS

Type	Size	Description	Nos.
D	3'-6" x 6'-9"	DOUBLE HUNG FRAMED & BATTENNED	5
D'	3'-3" x 6'-9"	SINGLE HUNG FRAMED & BATTENED	8+2
D²	2'-6" x 5'-6"	SINGLE HUNG LEDGED & BRACED ON PIVOT AT 6" HIGH FROM FLOOR LEVEL WITH OUT FRAME	6
D³	3'-3" x 6'-0"	SINGLE HUNG LEDGED & BRACED ON PIVOT WITH OUT FRAMES.	2
D⁴	8'-0" x 8'-0"	DOOR DOUBLE HUNG FRAMED & BATTENED	+1
W	2'-6" x 3'-9"	SINGLE HUNG GLAZED	2
W'	2'-9" x 3'-9"	SINGLE HUNG GLAZED	11+1
W²	5'-0" x 5'-0"	DOUBLE HUNG GLAZED	1
W³	2'-0" x 2'-6"	DOUBLE HUNG PANELLED	3
J	1'-6" x 3'-0"	COUNTRY MADE JALI	5
J'	15" x 15"	COUNTRY MADE JALI	20+8

	PLINTH AREA	APPROX. COST
MAIN BUILDING	2,430 SQ.FT.	RS. 15,650/-
" " INCLUDING FAMILY PLANNING & GARAGE	2,430+235 = 2,665 SQFT.	RS. 17,160/-

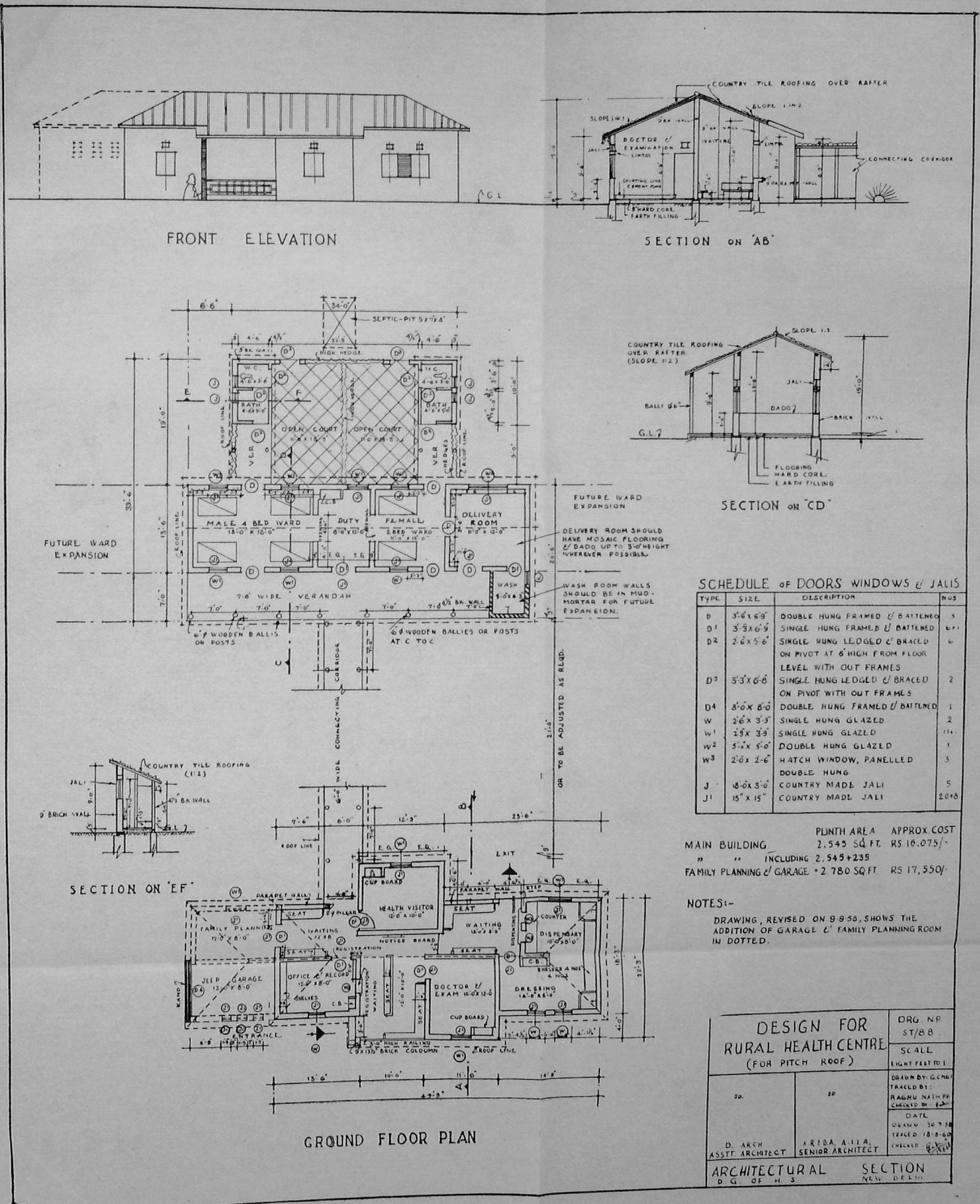
NOTES:-

DRAWING REVISED ON 9.9.58 SHOWS THE ADDITION OF GARAGE & FAMILY PLANNING ROOM IN DOTTED.

DESIGN FOR A RURAL HEALTH CENTRE (Flat Roof)		DRG. No. ST/89 Scale 8'-0" To 1"
Sd/- D. ARCH ASSTT. ARCHITECT	Sd/- A.R.I.B.A., A.I.I.A. SENIOR ARCHITECT	DRAWN BY: G.C. Malik. TRACED BY: K.N. Sharma. CHECKED BY: [signature] DATE DRAWN:- 30.3.58 TRACED:- 19.8.60

ARCHITECTURAL SECTION
D.G. of H.S. NEW DELHI.

APPENDIX "C"



SCHEDULE OF DOORS WINDOWS & JALIS

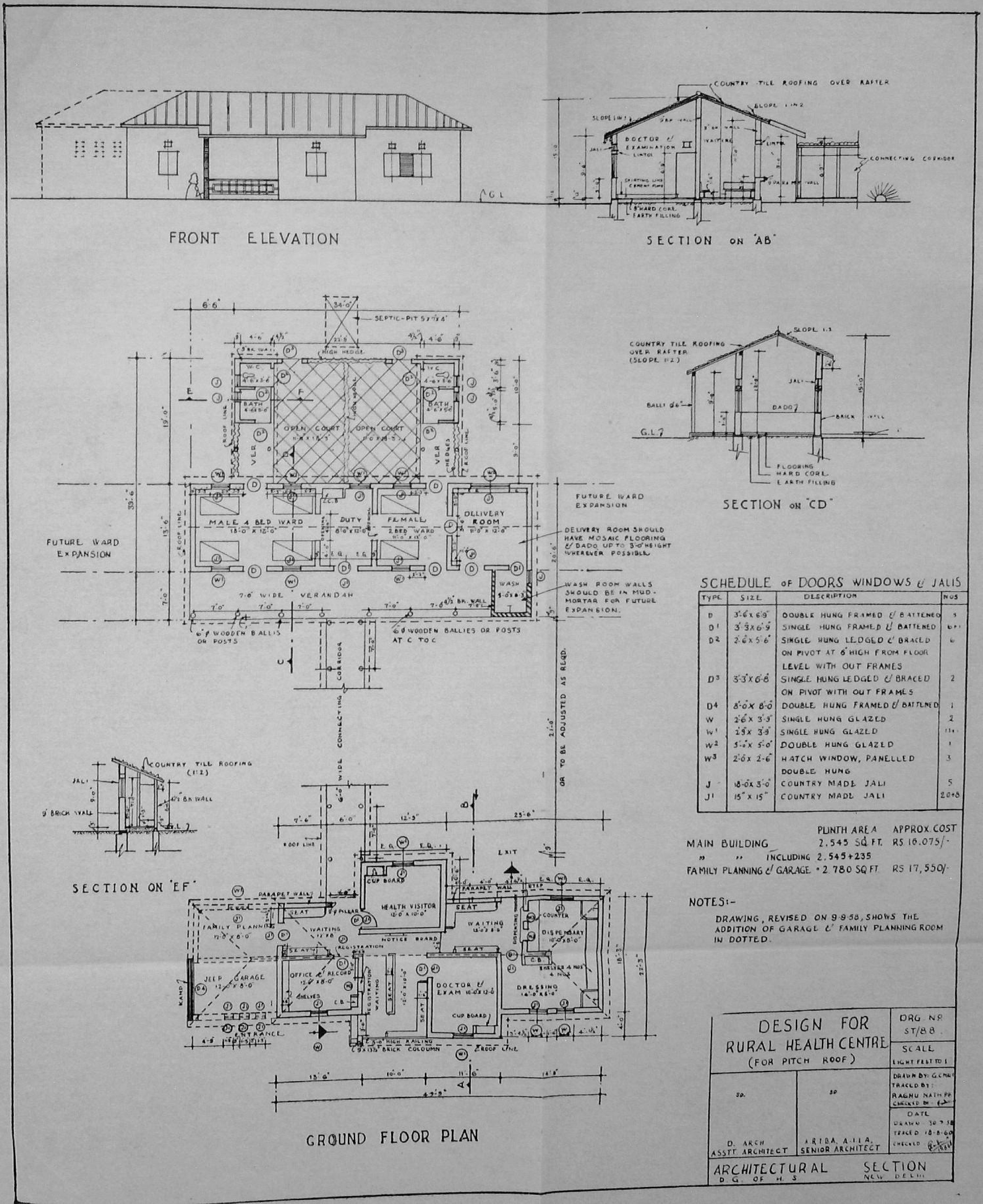
TYPE	SIZE	DESCRIPTION	NOS
D	3'-6" x 6'-9"	DOUBLE HUNG FRAMED & BATTENED	5
D[1]	3'-3" x 6'-9"	SINGLE HUNG FRAMED & BATTENED	6+1
D[2]	2'-6" x 5'-6"	SINGLE HUNG LEDGED & BRACED ON PIVOT AT 6" HIGH FROM FLOOR LEVEL WITH OUT FRAMES	6
D[3]	3'-3" x 6'-6"	SINGLE HUNG LEDGED & BRACED ON PIVOT WITH OUT FRAMES	2
D[4]	8'-0" x 8'-0"	DOUBLE HUNG FRAMED & BATTENED	1
W	2'-6" x 3'-3"	SINGLE HUNG GLAZED	2
W[1]	2'-9" x 3'-9"	SINGLE HUNG GLAZED	11+
W[2]	5'-0" x 5'-0"	DOUBLE HUNG GLAZED	1
W[3]	2'-0" x 2'-6"	HATCH WINDOW, PANELLED DOUBLE HUNG	3
J	18'-0" x 3'-0"	COUNTRY MADE JALI	5
J[1]	15" x 15"	COUNTRY MADE JALI	20+8

	PLINTH AREA	APPROX. COST
MAIN BUILDING	2,545 SQ. FT.	RS 16,075/-
" " INCLUDING	2,545+235	
FAMILY PLANNING & GARAGE	= 2,780 SQ FT	RS 17,550/-

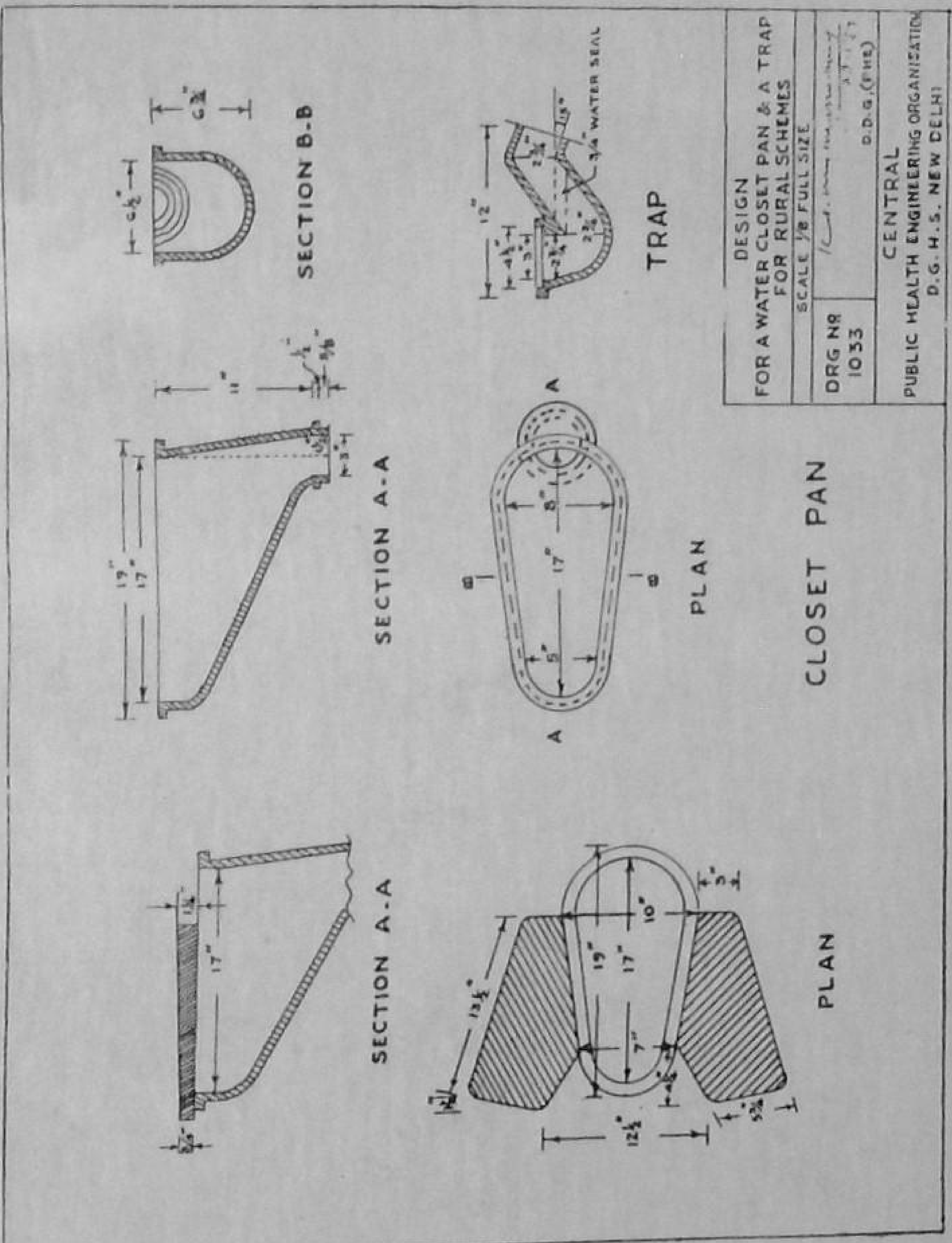
NOTES:-

DRAWING, REVISED ON 9-8-58, SHOWS THE ADDITION OF GARAGE & FAMILY PLANNING ROOM IN DOTTED.

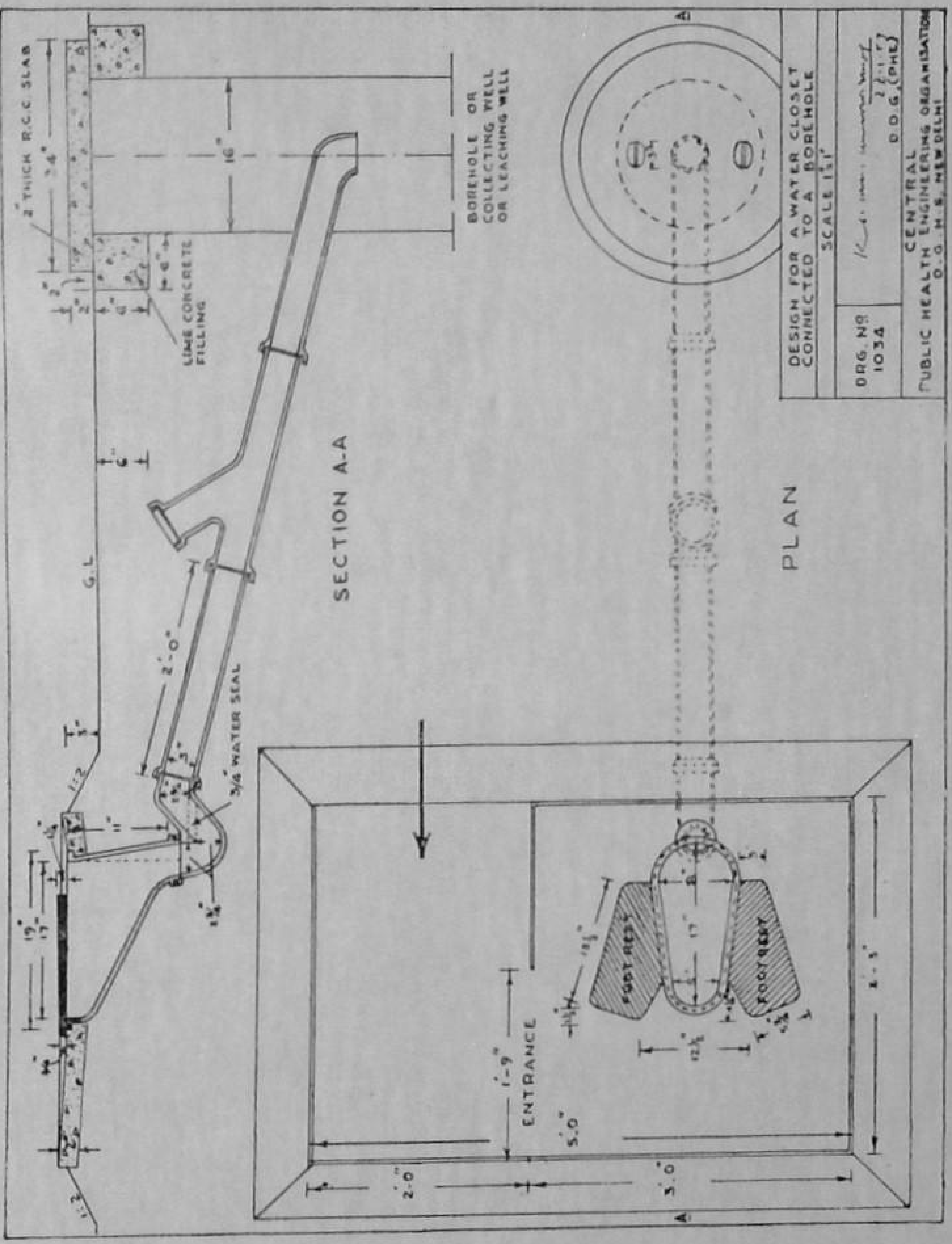
APPENDIX "C"


FRONT ELEVATION
G.L
SECTION ON "AB"
COUNTRY TILE ROOFING OVER RAFTER
SLOPE 1 IN 2
DOCTOR & EXAMINATION
WAITING
LINTOL
JALI
CONNECTING CORRIDOR
9" HARD CORE
EARTH FILLING
SECTION ON "CD"
COUNTRY TILE ROOFING OVER RAFTER (SLOPE 1:2)
SLOPE 1:1
JALI
BALLI
DADO
BRICK WALL
G.L
FLOORING
HARD CORE
EARTH FILLING
SEPTIC-PIT
HIGH HEDGE
OPEN COURT
OPEN COURT
W.C
BATH
BATH
VER
VER
ROOF LINE
MALE 4 BED WARD
DUTY
FEMALE 2 BED WARD
DELIVERY ROOM
FUTURE WARD EXPANSION
FUTURE WARD EXPANSION
DELIVERY ROOM SHOULD HAVE MOSAIC FLOORING & DADO UP TO 3'-0" HEIGHT WHEREVER POSSIBLE
WASH
WASH ROOM WALLS SHOULD BE IN MUD-MORTAR FOR FUTURE EXPANSION.
7'-0" WIDE VERANDAH
6" ϕ WOODEN BALLIS OR POSTS
6" ϕ WOODEN BALLIES OR POSTS AT C TO C
CORRIDOR
6'-0" WIDE CONNECTING CORRIDOR
OR TO BE ADJUSTED AS REQD.
COUNTRY TILE ROOFING (1:2)
JALI
9" BRICK WALL
SECTION ON "EF"
EXIT
PARAPET WALL
CUP BOARD
HEALTH VISITOR
SEAT
WAITING
FAMILY PLANNING
NOTICE BOARD
REGISTRATION
COUNTER
DISPENSARY
SHELVES
OFFICE & RECORD
JEEP GARAGE
DOCTOR & EXAM
DRESSING
CUP BOARD
ENTRANCE
HIGH RAILING
BRICK COLOUMN
ROOF LINE
GROUND FLOOR PLAN
SCHEDULE of DOORS WINDOWS & JALIS
TYPE | SIZE | DESCRIPTION | NOS
D | 3'-6" x 6'-9" | DOUBLE HUNG FRAMED & BATTENED | 5
D1 | 3'-3" x 6'-9" | SINGLE HUNG FRAMED & BATTENED | 6+1
D2 | 2'-6" x 5'-6" | SINGLE HUNG LEDGED & BRACED ON PIVOT AT 6" HIGH FROM FLOOR LEVEL WITH OUT FRAMES | 6
D3 | 3'-3" x 6'-8" | SINGLE HUNG LEDGED & BRACED ON PIVOT WITH OUT FRAMES | 2
D4 | 8'-0" x 8'-0" | DOUBLE HUNG FRAMED & BATTENED | 1
W | 2'-6" x 3'-3" | SINGLE HUNG GLAZED | 2
W1 | 2'-3" x 3'-3" | SINGLE HUNG GLAZED | 11+
W2 | 5'-0" x 5'-0" | DOUBLE HUNG GLAZED | 1
W3 | 2'-0" x 2'-6" | HATCH WINDOW, PANELLED DOUBLE HUNG | 3
J | 18'-0" x 3'-0" | COUNTRY MADE JALI | 5
J1 | 15" x 15" | COUNTRY MADE JALI | 20+8
PLINTH AREA APPROX. COST
MAIN BUILDING 2,545 SQ.FT. RS 16,075/-
" " INCLUDING 2,545+235
FAMILY PLANNING & GARAGE = 2,780 SQ.FT. RS 17,550/-
NOTES:-
DRAWING, REVISED ON 9-9-58, SHOWS THE ADDITION OF GARAGE & FAMILY PLANNING ROOM IN DOTTED.
DESIGN FOR RURAL HEALTH CENTRE (FOR PITCH ROOF)
DRG. NO ST/88
SCALE
EIGHT FEET TO 1
DRAWN BY: G.C.
TRACED BY: RAGHU NATH
CHECKED BY:
DATE
DRAWN 30-7-58
TRACED 18-8-60
CHECKED
SD.
SD.
D. ARCH ASSTT. ARCHITECT
A.R.I.B.A., A.I.I.A. SENIOR ARCHITECT
ARCHITECTURAL SECTION
D.G. OF H.S
NEW DELHI

APPENDIX "D"

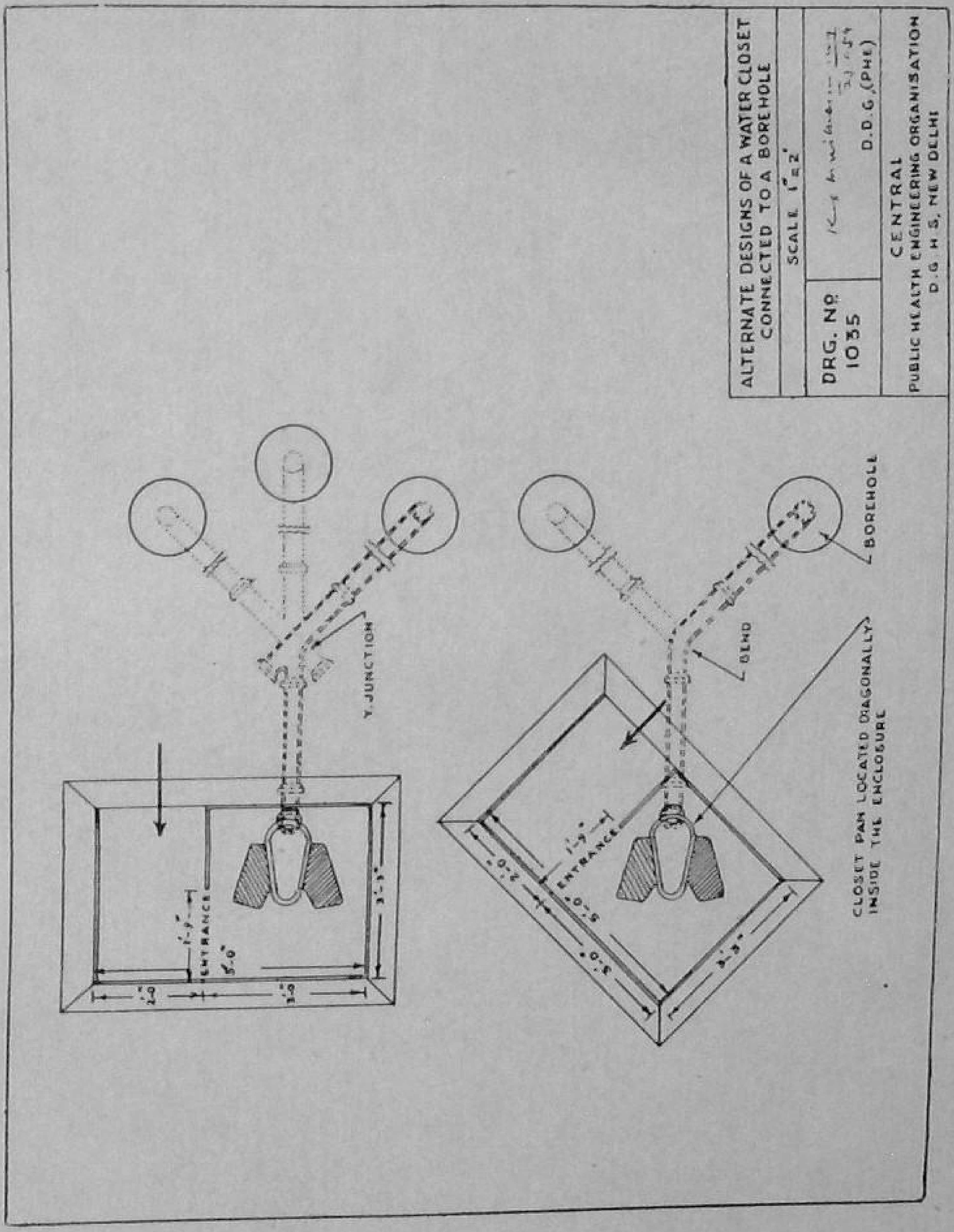

SECTION B-B
SECTION A-A
TRAP
3/4" WATER SEAL
PLAN
CLOSET PAN
SECTION A-A
PLAN
DESIGN
FOR A WATER CLOSET PAN & A TRAP
FOR RURAL SCHEMES
SCALE 1/8 FULL SIZE
DRG No
1033
D.D.G.(PHE)
CENTRAL
PUBLIC HEALTH ENGINEERING ORGANISATION
D.G.H.S. NEW DELHI

APPENDIX "D"



SECTION A-A
PLAN
2" THICK R.C.C. SLAB
LIME CONCRETE FILLING
BOREHOLE OR COLLECTING WELL OR LEACHING WELL
3/4" WATER SEAL
G.L
ENTRANCE
FOOT REST
FOOT REST
DESIGN FOR A WATER CLOSET CONNECTED TO A BOREHOLE
DRG. No 1034
D.D.G. (PHE)
CENTRAL PUBLIC HEALTH ENGINEERING ORGANISATION
D.G.H.S. NEW DELHI

APPENDIX "D"



L5CD&C—10,000—30—11—60—GIPF.